MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

00001

Reg. Dist. No. 6

1. PLACE OF DEATH:

County: Allegany

City or town: Westernport

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 45 yrs.

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Md. County: Allegany

City or town: Westernport

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME George Edward Ahern

3.(b) Social Security Number 213-16-9835

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: Anna Vesta Ahern

6.(c) If alive, give age: 35 years

7. Birth date of deceased (mo., day, yr.): Aug. 24, 1899

8. AGE:

Years	Months	Days	If less than one day
45	4	16	...hrs. ...min.

9. Birthplace: Westernport, Alleg. Md. (Town, county, and state)

10. Usual occupation: Laborer

11. Industry or business: Pulp & Paper Mill

FATHER 12. Name: John Thomas Ahern

FATHER 13. Birthplace: Westernport, Md.

MOTHER 14. Maiden name: Minnie Willis

MOTHER 15. Birthplace: Connellsville, Pa.

16. Informant: Mrs. George E. Ahern

Address: Westernport, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Jan. 13, 1945 (month) (day) (year)

Cemetery or crematory: Philos

Location: Westernport, Md.

18. Funeral director: Ellsworth D. Boal

Address: Westernport, Md.

19. Jan. 12 1945 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: January 10 1945, at 4 P. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ...19..., to ...19...

and that I last saw h...alive on ...19...

Immediate cause of death	DURATION
Coronary Occlusion	
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: --

Date of op.

Autopsy results: No autopsy

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide. Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE: Lewis H. Brown M.D. (M. D. or other)

Address: Cumberland Md. Date signed: 1-10-45

Deputy Medical Examiner - Allegany Co.

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

(M)

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (742)

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH:
County ALLEGANY
City or town CUMBERLAND, MD.
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 3 MONTHS 9 DAYS
Hospital, institution, or street address where death occurred: MEMORIAL HOSPITAL
How long in hospital or institution? 3 MONTHS 9 DAYS

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State MARYLAND County ALLEGANY
City or town CUMBERLAND
(If outside city or town limits, write RURAL and give nearest town)
Street No. 235 ELDER ST.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME PEARL AULT

3.(b) Social Security Number None

4. Sex FEMALE
5. Color or race WHITE
6.(a) Single, married, widowed, or divorced WIDOW
6.(b) Name of husband or wife RENNIE AULT (DECEASED)
6.(c) If alive, give age ... years
7. Birth date of deceased (mo., day, yr.) JAN. 9, 1897

8. AGE: Years	Months	Days	If less than one day
48	0	10	... hrs. ... min.

9. Birthplace W. VA.
(Town, county, and state)
10. Usual occupation UNABLE TO WORK
11. Industry or business Housewife
FATHER 12. Name COSNER, HARRISON
13. Birthplace W. VA.
MOTHER 14. Maiden name ELLEN NINE
15. Birthplace W. VA.
16. Informant Memorial Hospital
Address Cumberland, Md.
17. Burial (Burial, cremation, or removal. Which?) Date thereof Jan. 23 1945 (month) (day) (year)
Cemetery or crematory Church of the Brethern
Location Maysville, W. Va.
18. Funeral director John J. Hafer
Address Cumberland, Md.
19. Jan. 23, 1945 (Date rec'd by registrar) Winter R. Frantz, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 1-19-1945, at 11:20 P
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Oct. 19 1944, to 1-19-1945
and that I last saw her alive on 1-19-1945

Immediate cause of death Aplastic Myelogenous Leukemia (?) — DURATION 4 yrs.
Due to
Due to
Other conditions
(Include pregnancy within 3 months of death)
Major findings of operations None
Date of op. None
Autopsy results None
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE Wm. F. Williams M. D. or other
Address Cumberland Date signed 1-30-45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (63-M)

CERTIFICATE OF DEATH

00003

Reg. Dist. No. 10

1. PLACE OF DEATH:
County: Allegany
City or town: Mt. Savage
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? all his life
Hospital, Institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Allegany
City or town: Mt. Savage
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME: Robert Henry Barth

3.(b) Social Security Number: 214-07-6793

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: Mary A. Barth
6.(c) If alive, give age: 32 years

7. Birth date of deceased (mo., day, yr.): March 30. 1908

8. AGE: Years	Months	Days	If less than one day
36	10		hrs. min.

9. Birthplace: Mt. Savage, Allegany Cty., Md.
(Town, county, and state)
10. Usual occupation: Draftsman
11. Industry or business: Kelly-Springfield Tire Co.
FATHER 12. Name: Edward Barth,
13. Birthplace: Maryland
MOTHER 14. Maiden name: Jeanne Graham,
15. Birthplace: Maryland
16. Informant: Daniel Arnold,
Address: Mt. Savage, Md.
17. Burial (Burial, cremation, or removal. Which?) Date thereof Feb. 3, 1945 (month) (day) (year)
Cemetery or crematory: St. George's Episcopal
Location: Mt. Savage, Md.
18. Funeral director: J. J. Durst,
Address: Frostburg, Md.
19. Feb 1- 1945 (Date rec'd by registrar) Veronica McDermitt Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: January 30th., 1945, at about 8 P.M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ..... 19..., to ..... 19...
and that I last saw h... alive on ..... 19...

Immediate cause of death	DURATION
Suicide by Carbon Mon-oxide	about
Poisoning (exhaust fumes from	5 min.
automobile engine)	
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)
Major findings of operations: ---
Date of op.
Autopsy results: no autopsy
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: suicide Date of 1-30-45
Where did injury occur? Mt. Savage, Allegany, Md.
(City or town) (County) (State)
Injured at home, farm, industry, public place (where?) garage, at home
Means of injury: exhaust gas from car. Injured at work? no

23. SIGNATURE: Percy H. Brason M.D.
M. D. or other
Address: Cumberland, Maryland Date signed: 1-31-45
Deputy Medical Examiner - Allegany Co.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

00064

Reg. Diat. No. 4

1. PLACE OF DEATH:

County: Allegany

City or town: Cumberland

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred: Memorial Hospital

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Md. County: Allegany

City or town: Cumberland.

(If outside city or town limits, write RURAL and give nearest town)

Street No. 1315 Virginia Ave.

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME Sandra Kay Benson

3. (b) Social Security Number None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Child.

6.(b) Name of husband or wife

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) Oct 1, 1944.

8. AGE:

Years	Months	Days	If less than one day
0	3	26	..... hrs. ..... min.

9. Birthplace: Cumberland, Allegany Co., Md (Town, county, and state)

10. Usual occupation: Child

11. Industry or business

FATHER

12. Name: Chester Benson

13. Birthplace: North Branch, Md.

MOTHER

14. Maiden name: Madona Burgess

15. Birthplace: Cumberland, Md

16. Informant: Chester Benson

Address: 1315 Va. Ave - Cumberland Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof Jan. 30 1945 (month) (day) (year)

Cemetery or crematory: Rose Hill Methodist Cem

Location: Near Oldtown Road.

18. Funeral director: John J. Hafer

Address: Cumberland, Md.

19. Jan. 30, 19 45 (Date rec'd by registrar) Walter R. Frantz, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Jan 27 1945, at 4:23 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan. 27, 1945, to Jan 27, 1945, and that I last saw h[illegible] alive on Jan 27, 1945

Immediate cause of death	DURATION
Bronchopneumonia	7 days
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE: Clay R. Lemon M. D. or other

Address: Cumberland Date signed Jan. 27, 1945

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (77)

CERTIFICATE OF DEATH

00005

Reg. Dist. No. 4

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County: Allegany

City or town: Cumberland.

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 75 yrs.

Hospital, institution, or street address where death occurred: 412 S. Cedar St.

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Allegany

City or town: Cumberland

(If outside city or town limits, write RURAL and give nearest town)

Street No. 412 S. Cedar St.

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME Joseph Bernard Blocker

3.(b) Social Security Number None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: Fannie Bowers.

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Sept. 7 1876

8. AGE:

Years	Months	Days	If less than one day
68	4	8	hrs. min.

9. Birthplace: Oil City Pa.

(Town, county, and state)

10. Usual occupation: Janitor

11. Industry or business: General jobs.

FATHER

12. Name: Jos. E. Blocker

13. Birthplace: Pa.

MOTHER

14. Maiden name: Anna Mae Hupp

15. Birthplace: Pa.

16. Informant: Mrs Ed Brown.

Address: 453 Grotte St Cumb'd.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Jan 18 45 (month) (day) (year)

Cemetery or crematory: Rose Hill Cem.

Location: Cumberland

18. Funeral director: Louis Stein Jr.

Address: Cumberland.

19. Jan. 17 1945 (Date rec'd by registrar) Winter R. Beauty M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Jan. 15 1945 at 11:45 P.M.

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from Sept. 15 1944 to Jan. 15 1945 and that I last saw him alive on Jan. 15 1945

Immediate cause of death	DURATION
Generalized Arteriosclerosis	5 yrs.
Due to: Uraemia	10 days
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: Mary E. Jarrett M. D. or other

Address: Cumberland Date signed: Jan. 16, 1945

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (21)

CERTIFICATE OF DEATH

00006

Reg. Dist. No. 10

1. PLACE OF DEATH:

County: Allegany

City or town: Mount Savage Md

(If outside city or town limits, write RURAL, and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Md. County: Allegany

City or town: Mt Savage

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME Margut Bowers

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F	W	widowed

8.(b) Name of husband or wife: Mack Bowers

8.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Feb 6 — 1867

8. AGE:

Years	Months	Days	If less than one day
77	11	3	hrs. min.

9. Birthplace: Mt Savage - Alleg - Md. (Town, county, and state)

10. Usual occupation: Housewife

11. Industry or business

FATHER 12. Name: Colin Graham

13. Birthplace: Scotland

MOTHER 14. Maiden name: Margut Nairn

15. Birthplace: Scotland

18. Informant: Colin Bowers

Address: Mt Savage Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Jan 11 45 (month) (day) (year)

Cemetery or crematory: St George

Location: Mt Savage

18. Funeral director: J. O. Hunter

Address: Frostburg

19. 1 - 10 - 1945 (Date rec'd by registrar) Vernon M. Bennett Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: January 9th 1945, at 6:30 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from November 1944, to Jan. 8th 1945

and that I last saw h. alive on January 8 1945

Immediate cause of death: Apoplexy — DURATION: 2 mo -

Due to: Cerebral Hypertension — DURATION: —

Due to: — DURATION: From Husband about 8 years.

Other conditions: Mitral & Aortic Regurgitation -

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: William E. Moseley M.D.

M. D. or other

Address: Mt Savage Md. Date signed: Jan. 10 - 45

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (93-d)

00007

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH:
County: Allegany
City or town: Cumberland
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 2 wks.
Hospital, institution, or street address where death occurred: Memorial Hospital
How long in hospital or institution? 4 days.

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County:
City or town: Edgewood Arsenal
(If outside city or town limits, write RURAL and give nearest town)
Street No.: Building Arsenal
(If rural, give LOCATION)
2.(a) If veteran, name war: I & II World War V

3.(a) FULL NAME: Lt. Col. Hugh S Brady
Serial No. 0-916856
3.(b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: Frances S. Sloan
6.(c) If alive, give age: 55 years

7. Birth date of deceased (mo., day, yr.): June 26 1888

8. AGE:

Years	Months	Days	If less than one day
56	6	17	hrs. min.

9. Birthplace: Harrodsville Virginia
(Town, county, and state)
10. Usual occupation: Lt. Col. U.S. Army
11. Industry or business

FATHER
12. Name: Alfred Brady
13. Birthplace: Virginia

MOTHER
14. Maiden name: Mildred Scott
15. Birthplace: Virginia

16. Informant: David Sloan
Address: Cumberland Md.

17. Burial + Removal (Burial, cremation, or removal. Which?) Date thereof 1-16-45 (month) (day) (year)
Cemetery or crematory: Arlington Cem.
Location: Arlington, Va.
18. Funeral director: Louis Stein Inc.
Address: Cumberland, Md.

19. Jan. 15 1945 (Date rec'd by registrar) Walter R. Frantz, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Jan 13 1945, at 1:35 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from January 9 1945 to January 13 1945 and that I last saw h[im] alive on January 13 1945

Immediate cause of death	DURATION
Coronary Occlusion	4 days
Myocardial disease	"
Due to: Arteriosclerosis	
Myocardial infarction	
Due to:	
Other conditions: Uremia	2 days

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of:
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?):
Means of injury: Injured at work?

23. SIGNATURE: Samuel A. Jacobson M.D.
M. D. or other
Address: 15 S. Liberty St. Date signed: 1/13/45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (131-E)

CERTIFICATE OF DEATH

00608

Reg. Diat. No. 9

1. PLACE OF DEATH:

County Allegany

City or town Hoffman (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? All his life

Hospital, Institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants, give residence of mother)

State Maryland County Allegany

City or town Hoffman (If outside city or town limits, write RURAL and give nearest town)

Street No. (If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME Phillip Frederick Brode

3.(b) Social Security Number none

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Widowed

6.(b) Name of husband or wife Elizabeth S. Brode

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) September 25 1875

8. AGE: Years	Months	Days	If less than one day
69	3	27	..... hrs. ..... min.

9. Birthplace Hoffman Allegany Cty. Md (Town, county and state)

10. Usual occupation Retired Trader

11. Industry or business Coal mines

MOTHER FATHER

12. Name Phillip Brode

13. Birthplace Germany

MOTHER

14. Maiden name Mary Sipple

15. Birthplace Unknown

19. Informant Mrs. Hugh Croston

Address Hoffman, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Jan 25-1945 (month) (day) (year)

Cemetery or crematory Allegany Cemetery

Location Frostburg Md

18. Funeral director J. J. Durst

Address Frostburg Md.

19. 1-24 19 45 Mrs Laney V. Rose Registrar

(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH January 22 1945 at 6:30 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Sept 10 1944 to Jan 22 1945 and that I last saw him alive on Jan 21 1945

Immediate cause of death Chronic Nephritis — DURATION

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations ..... Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ..... Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury ..... Injured at work?

23. SIGNATURE L B Mathews M. D. or other

Address 49 Greene St Date signed 1-23-45

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (94)

00009

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH:
County Allegany
City or town Cumberland
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred:
Allegany Hospital
How long in hospital or institution? 18 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Allegany
City or town Cumberland
(If outside city or town limits, write RURAL and give nearest town)
Street No. 310 Washington St.
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME William B. Brown

3. (b) Social Security Number None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife Mary Brown 6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 21, 1876

8. AGE: Years	Months	Days	If less than one day
68	10	4	hrs. min.

9. Birthplace Maryland Baltimore (Town, county, and state)
10. Usual occupation X Ray Salesman
11. Industry or business Kelly Koett Co

FATHER
12. Name James T. Brown
13. Birthplace Annapolis Md

MOTHER
14. Maiden name Mary A. Hales
15. Birthplace Baltimore Md

16. Informant Mrs. William B. Brown
Address 310 Washington St.

17. Burial Date thereof Jan 27 1945
(Burial, cremation, or removal. Which?) (month) (day) (year)
Cemetery or crematory Baltimore Cemetery
Location Baltimore, Md.

18. Funeral director John J. Hoffer
Address Cumberland, Md.

19. Jan 25 1945 Wister R. Frantz M.D.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH January 25 1945 at 2:37 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan 17 1944 to Jan 25 1945 and that I last saw him alive on Jan 25 1945

	DURATION
Immediate cause of death: Cerebral Hemorrhage	10 yrs?
Due to: Coronary occlusion	Since Jan 7
Due to: Myocardial infarction	" " "
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE Wister R. Frantz M.D.
M. D. or other
Address 36 Greene St Date signed 1/25-45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS-A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (94-a)

CERTIFICATE OF DEATH

00610

Reg. Diat. No. 4

1. PLACE OF DEATH:
County: Allegany
City or town: Cumberland Md
(If ontside city or town limits, write RURAL and give nearest town)
How long in above place of death? 3 weeks 3 days
Hospital, Institution, or street address where death occurred:
Allegany Hospital
How long in hospital or institution? 3 weeks 3 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Allegany
City or town: Lonaconing
(If outside city or town limits, write RURAL and give nearest town)
Street No.: Detmold
(If rural, give LOCATION)
2.(a) If veteran, name war: —

3.(a) FULL NAME: Wilhelmina Wiland (Cameron)

3.(b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Married

6.(b) Name of husband or wife: James L. Cameron
6.(c) If alive, give age: 64 years

7. Birth date of deceased (mo., day, yr.): Sept 10, 1882

8. AGE: Years	Months	Days	If less than one day: hrs.	min.
62	4	17		

9. Birthplace: Lonaconing Allegany Co., Md. (Town, county, and state)
10. Usual occupation: Housework
11. Industry or business: Own Home
FATHER — 12. Name: Cyrus Wiland
13. Birthplace: Pa
MOTHER — 14. Maiden name: Elizabeth Gray
15. Birthplace: Wales
16. Informant: Mrs. Archie Cameron
Address: Lonaconing, Md.
17. Burial (Burial, cremation, or removal. Which?) Date thereof: Jan 30 1945 (month) (day) (year)
Cemetery or crematory: Oak Hill Cemetery
Location: Lonaconing, Md.
18. Funeral director: McEachron
Address: Lonaconing, Md.
19. Jan 30 1945 (Date rec'd by registrar) Wilbur L. Frantz M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Jan 27 1945, at M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan 3 1945, to Jan 27 1945, and that I last saw h.. alive on Jan 27 1945

Immediate cause of death	DURATION
Hypertention	10 yrs
Due to Patent coronary occlusion with myocardial infarction	3 wks
Due to —	
Other conditions —	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following: —
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: Cyrus R. Eberhart M.D. M. D. or other
Address: 36 Greene St Cumberland Md Date signed: 1/29-45

VS A15

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 93d

00011

CERTIFICATE OF DEATH

Reg. Diat. No. 4

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County: Allegany

City or town: Cumberland

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 5 Years

Hospital, institution, or street address where death occurred:

Allegany Hospital

How long in hospital or institution? 42 Days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Allegany

City or town: Cumberland

(If outside city or town limits, write RURAL and give nearest town)

Street No. 115 North Allegany St

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME

Mary Canty

3. (b) Social Security Number

None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Single

6.(b) Name of husband or wife

6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) August 10 1881

8. AGE: Years	Months	Days	If less than one day
63	5	0	hrs. min.

8. Birthplace: Hutton, Garrett Co, Maryland (Town, county, and state)

10. Usual occupation: House Duty

11. Industry or business: Own House

FATHER

12. Name: William Canty

13. Birthplace: Germany

MOTHER

14. Maiden name: Mary (Unknown)

15. Birthplace: Germany

16. Informant: William Sluss

Address: 115 N. Allegany St, Cumberland, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 1/12/45 (month) (day) (year)

Cemetery or crematory: St Peter Cemetery

Location: Oakland, Maryland

18. Funeral director: William H. Kight

Address: Cumberland, Md.

19. Jan 11 1945 Winter R. Canty M.D. Registrar

(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH: January 10 1945 at 10 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Oct 31 1944 to Jan 10 1945 and that I last saw her alive on Jan 9 1945

Immediate cause of death	DURATION
Chronic myocarditis	2 yrs
Due to	
Due to	
Other conditions Arteriosclerosis	18 mos

(Include pregnancy within 3 months of death)

Major findings of operation

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE: R. A. Trevaskis, M.D.

M. D. or other

Address: Cumberland Md Date signed: Jan 10-45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

00012

Reg. Diat. No. 4

1. PLACE OF DEATH:

County: Allegany

City or town: Cumberland, Md

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred: Allegany Hospital Cumberland Md

How long in hospital or institution? 2 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Allegany

City or town: Creeptown Md

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME Clingerman, Jerry

3. (b) Social Security Number None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Single

6.(b) Name of husband or wife

6.(c) If alive, give age ____ years

7. Birth date of deceased (mo., day, yr.) June 1, 1944

8. AGE: Years	Months	Days	If less than one day
	7	13	____ hrs. ____ min.

9. Birthplace: Maryland (Town, county, and state)

10. Usual occupation: None

11. Industry or business

FATHER — 12. Name: Richard Clingerman

13. Birthplace: Ft. Va

MOTHER — 14. Maiden name: Minnie Mongold

15. Birthplace: Ft. Va

16. Informant: Mrs Richard Clingerman

Address: Creeptown Md

17. Buried (Burial, cremation, or removal. Which?) Date thereof 1/16/45 (month) (day) (year)

Cemetery or crematory: Petersburg W. Va. Cem.

Location: Petersburg W Va.

18. Funeral director: Earle Burch

Address: Petersburg W Va.

19. Jan. 16, 1945 (Date rec'd by registrar) Winter R. Beauty, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 1/14/45, at 1:05 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 1-11-1945 to 1-14-1945 and that I last saw h.. alive on 1-14-1945

Immediate cause of death	DURATION
gastro-enteritis	3 days
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide. Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE: L Brinn MD (M. D. or other)

Address: Terra Md Date signed 1-14-45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

Evidence for change of age of deceased is shown on FILM No. G 92 MAR 10 1945

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (48-a)

CERTIFICATE OF DEATH

00013

Reg. Dist. No. 4

1. PLACE OF DEATH:
County Allegany
City or town Cumberland Md.
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred: Allegany Hospital, Cumberland, Md
How long in hospital or institution? 14 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Allegany
City or town Cumberland Md
(If outside city or town limits, write RURAL and give nearest town)
Street No. 440 Walnut St
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME Clites, Mrs. Lydia

3. (b) Social Security Number None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F	White	Widowed

6.(b) Name of husband or wife
6.(c) If alive, give age ... years

7. Birth date of deceased (mo., day, yr.) April 14th, ~~1869~~ 1877

8. AGE: Years	Months	Days	If less than one day
67	3	12	hrs. min.

9. Birthplace Pa. (Town, county, and state)
10. Usual occupation Housewife
11. Industry or business
FATHER 12. Name Jesse Mason
13. Birthplace Pennsylvania
MOTHER 14. Maiden name Laura Devore
15. Birthplace Pennsylvania
16. Informant Mrs. Edith Miller
Address Cumberland, Md
17. Burial (Burial, cremation, or removal. Which?) Date thereof Nov. 5, 1945 (month) (day) (year)
Cemetery or crematory Hyndman
Location Hyndman, Pa
18. Funeral director Harvey N. Teeter
Address Hyndman, Pa
19. Jan. 4, 1945 (Date rec'd by registrar) Winter K. Mantz M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH January 2 1945, at 4:05 P.M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 10/18/44 19... to 1/2/45 19... and that I last saw her alive on 1/2/45 19...

	DURATION
Immediate cause of death Carcinoma of cervix uteri; metastasis	
Due to Retention, vagina	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)
Major findings of operations Carcinoma cervix; nodules Date of op. 12/20/44
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide ... Date of ...
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE John K Lowe M D M. D. or other
Address Cumberland Md Date signed 1/3/45

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (51-P)

CERTIFICATE OF DEATH

00014

Reg. Dist. No. 4

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County ALLEGANY

City or town CUMBERLAND, MD.
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, Institution, or street address where death occurred:
MEMORIAL HOSPITAL

How long in hospital or institution? 2 DAYS

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State MARYLAND County ALLEGANY

City or town FROSTBURG.
(If outside city or town limits, write RURAL and give nearest town)

Street No. 239 E. UNION STREET
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME CLOSE, JAMES MR.

3. (b) Social Security Number None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
MALE	WHITE	MARRIED

6.(b) Name of husband or wife BRODE, LENA

6.(c) If alive, give age 68 years

7. Birth date of deceased (mo., day, yr.) 9-28-1878

8. AGE: Years	Months	Days	If less than one day
66	3	28	hrs. min.

9. Birthplace MARYLAND
(Town, county, and state)

10. Usual occupation RETIRED - Saddle Shop

11. Industry or business Proprietor

FATHER 12. Name CLOSE, JAMES

FATHER 13. Birthplace MARYLAND

MOTHER 14. Maiden name DUDLEY, MARGARET

MOTHER 15. Birthplace MARYLAND

16. Informant MEMORIAL HOSPITAL

Address CUMBERLAND

17. Burial (Burial, cremation, or removal. Which?) Date thereof Jan 28 1945 (month) (day) (year)

Cemetery or crematory Allegany Cemetery

Location Frostburg Md.

18. Funeral director Jacob Hafer.

Address 238 Main Frostburg Md

19. Jan. 27, 1945 (Date rec'd by registrar) Winter R. Frantz, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH JAN. 26 1945 19 at 625 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 1-24- 19 45 to 1-26- 19 45

and that I last saw h.[illegible] alive on 1-25- 19 45

Immediate cause of death	DURATION
Carcinoma of prostate	
Due to	
Due to	
Other conditions Myocardial degeneration	

(Include pregnancy within 3 months of death)

Major findings of operations no oper. Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Howard L. Folson M.D.
M. D. or other

Address Cumberland Md Date signed 1-26-45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

00015

Reg. Dist. No. 4

1. PLACE OF DEATH:

County: Allegany

City or town: Cumberland
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 10 days

Hospital, institution, or street address where death occurred: Memorial Hospital

How long in hospital or institution? 10 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Pennsylvania County: Bedford

City or town: Hyndman
(If outside city or town limits, write RURAL and give nearest town)

Street No.
(If rural, give LOCATION)

2.(a) If veteran, name war: ✓

3.(a) FULL NAME Marian Henrietta Coughenour

3.(b) Social Security Number None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Married

6.(b) Name of husband or wife: Stephen Coughenour

6.(c) If alive, give age: 46 years

7. Birth date of deceased (mo., day, yr.): January 13, 1903

8. AGE: Years	Months	Days	If less than one day
41	11	19	... hrs. ... min.

9. Birthplace: Johnstown, Pa.
(Town, county, and state)

10. Usual occupation: Housewife

11. Industry or business: —

FATHER
12. Name: E. E. Johns
13. Birthplace: England

MOTHER
14. Maiden name: Clara Johns
15. Birthplace: England

16. Informant: Stephen Coughenour
Address: Hyndman, Pa.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Jan. 5, 1945 (month) (day) (year)

Cemetery ~~or crematory~~: Hyndman

Location: Hyndman

18. Funeral director: H. H. Feigley

Address: Hyndman, Pa.

19. Jan. 4, 1945 (Date rec'd by registrar) Walter R. Frantz, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Jan 2, 1945, at 5:30 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 1944, to Jan 2 1945 and that I last saw h. ER alive on Jan 2 1945

Immediate cause of death	DURATION
Meningo-Vascular Syphilis	6 yrs.
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ... Date of op. ...

Autopsy results: ...

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ... Date of ...

Where did injury occur? ... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) ...

Means of injury ... Injured at work?

23. SIGNATURE: John A Tapper M.D.
M. D. or other

Address: Hyndman Pa Date signed: 1-3-45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

DR. HODGES Williams

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 30-1

00616

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH:
County Allegany
City or town Cumberland, Maryland
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred:
Memorial Hospital
How long in hospital or institution? 77 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Allegany
City or town Cumberland
(If outside city or town limits, write RURAL and give nearest town)
Street No. 311 Washington Street
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME
Mr. Eddie Lee Craig

3. (b) Social Security Number
None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	Colored	Single

6.(b) Name of husband or wife Unknown
6.(c) If alive, give age ..... years
7. Birth date of deceased (mo., day, yr.) Unknown

8. AGE: Years	Months	Days	If less than one day
About 65			hrs. ..... min.

9. Birthplace Unknown
(Town, county, and state)
10. Usual occupation Handy-man
11. Industry or business
FATHER 12. Name John Craig
13. Birthplace Unknown
MOTHER 14. Maiden name Martha
15. Birthplace Unknown
16. Informant Memorial Hospital
Address Cumberland, Md.
17. Burial (Burial, cremation, or removal. Which?) Date thereof Jan 4 45 (month) (day) (year)
Cemetery or crematory Allag Co Cem
Location Cumberland Md
18. Funeral director Louis Fleer Jr
Address Cumberland Md
19. Jan. 4 1945 (Date rec'd by registrar) Winter R. Krantz, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH January 1 1945, at 6:30A M
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Oct. 16 1944 to 1-1- 1945
and that I last saw h alive on 12-31- 1944

	DURATION
Immediate cause of death: Chronic Valvular Heart Disease	
Due to: Syphilis	
Due to: Syphilitic Aortitis	
Due to: Chronic Prostatitis	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations None
Date of op. None
Autopsy results None
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE W. F. Williams M. D. or other
Address Cumberland Md Date signed 1-5-45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

DR. TOLSON

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (133a)

CERTIFICATE OF DEATH

00617

Reg. Dist. No. 4

1. PLACE OF DEATH:
County ALLEGANY
City or town CUMBERLAND, MARYLAND
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 16 da
Hospital, institution, or street address where death occurred:
Memorial Hospital
How long in hospital or institution? 16 DAYS

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State WEST VIRGINIA County PRESTON
City or town ALBRIGHT
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war √

3.(a) FULL NAME FRANK W. CRANE

3.(b) Social Security Number None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
MALE	WHITE	MARRIED

6.(b) Name of husband or wife MYRTLE STRAWSER CRANE
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) MARCH 31, 1881

8. AGE: Years	Months	Days	If less than one day
63	10	6	....hrs. ....min.

9. Birthplace W. VA.
(Town, county, and state)
10. Usual occupation SERVICE STATION AND GROCERY
11. Industry or business STORE

FATHER
12. Name JOHN C. CRANE
13. Birthplace W. VA.

MOTHER
14. Maiden name MOLLIE R. BISHOP
15. Birthplace W. VA.

16. Informant MEMORIAL HOSPITAL
Address CUMBERLAND, MD.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Feb. 3 1945 (month) (day) (year)
Cemetery or crematory Kingwood Cemetery
Location Kingwood, W. Va.
18. Funeral director Spindler Funeral Home
Address Kingwood, W. Va.
19. Feb 1 1945 (Date rec'd by registrar) Winter R. Frantz, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH JAN. 31, 1945 5:20 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 1-13- 1945 to 1-31- 1945
and that I last saw h.i.m. alive on 1-31- 1945

Immediate cause of death	DURATION
(a) Chronic Pyelonephritis Complicated with Uremia	
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE Theodore L. Tolson M.D. M. D. or other
Address Cumberland, Md. Date signed 1-31-45

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 50

CERTIFICATE OF DEATH

00618

Reg. Diat. No. 4

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS-A15

1. PLACE OF DEATH:

County: Allegany

City or town: Cumberland

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 55 Years

Hospital, Institution, or street address where death occurred: 314. Grand Ave

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Allegany

City or town: Cumberland

(If outside city or town limits, write RURAL and give nearest town)

Street No. 314. Grand Ave

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME: Flora Elizabeth Cunningham

3.(b) Social Security Number: 214-05-5118

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Widow

6.(b) Name of husband or wife: Samuel A. Cunningham

6.(c) If alive, give age: ..... years

7. Birth date of deceased (mo., day, yr.): October 31, 1883

8. AGE: Years	Months	Days	If less than one day
61	2	28	..... hrs. ..... min.

9. Birthplace: Oldtown, Allegany Co, Maryland (Town, county, and state)

10. Usual occupation: Cook

11. Industry or business: Restraunt

FATHER

12. Name: Unknown

13. Birthplace: Unknown

MOTHER

14. Maiden name: Unknown

15. Birthplace: Unknown

16. Informant: Miss Irene Cunningham

Address: 314. Grand Ave, Cumberland, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 2/2/45 (month) (day) (year)

Cemetery or crematory: St Patricks Cemetery

Location: Cumberland, Md.

18. Funeral director: William H. Kight

Address: Cumberland, Md.

19. Feb. 1, 1945 (Date rec'd by registrar) Winter R. Franks M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Jan 29, 1945, at 11:45 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from April 2, 1944 to Jan 29, 1945

and that I last saw her alive on Jan 29, 1945

Immediate cause of death	DURATION
Pneumonia	2 Days
Due to: Influenza	2 Days
Due to:	
Other conditions	

(Incinde pregnancy within 3 months of death)

Major findings of operations: no

Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: M. D. or other

Address: 133 Va ave Date signed: 1/30/45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 93d

00019

CERTIFICATE OF DEATH

Reg. Diat. No. 8

1. PLACE OF DEATH:
County: Allegany
City or town: Lonaconing
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 47 years
Hospital, institution, or street address where death occurred: —
How long in hospital or institution? —

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Allegany
City or town: Lonaconing
(If outside city or town limits, write RURAL and give nearest town)
Street No. —
(If rural, give LOCATION)
2.(a) If veteran, name war —

3. (a) FULL NAME: Ida M. Green Cutter

3. (b) Social Security Number: —

4. Sex: Female
5. Color or race: White
6.(a) Single, married, widowed, or divorced: Married
6.(b) Name of husband or wife: William F. Cutter
6.(c) If alive, give age: 73 years
7. Birth date of deceased (mo., day, yr.): Nov 22, 1878
8. AGE: Years: 66 Months: 1 Days: 15 If less than one day: hrs. min.
9. Birthplace: Farm - Garrett Co., (Town, county, and state)
10. Usual occupation: Housework
11. Industry or business: Own home
FATHER 12. Name: Simeon Green
13. Birthplace: Farm - Garrett Co. Md.
MOTHER 14. Maiden name: Eliza Broadwaters
15. Birthplace: Farm, Garrett Co. Md.
16. Informant: David Cutter
Address: Midland, Md.
17. Burial (Burial, cremation, or removal. Which?) Date thereof Jan. 10, 1945 (month) (day) (year)
Cemetery or crematory: Home Burying Ground
Location: Lonaconing, Md.
18. Funeral director: M. Eichhorn
Address: Lonaconing, Md.
19. Jan. 10 1945 (Date rec'd by registrar) Dr. E. Bond Jr. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: January 7, 1945, at 11:50 P.M.
21. I CERTIFY that death occurred on the date above stated: that I attended deceased from July 1, 1943 to Jan 7 1945
and that I last saw h... alive on Jan 7 1945

	DURATION
Immediate cause of death: Chronic Myocarditis	5 years
Due to:	
Due to:	
Other conditions: Gangrene R. Leg	2 wks

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of:
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?):
Means of injury: Injured at work?

23. SIGNATURE: P. E. Berry M.D.
M. D. or other
Address: Piedmont W. Va. Date signed 1/10/45

VS A15

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (93-d)

CERTIFICATE OF DEATH

06620

Reg. Dist. No. 4

1. PLACE OF DEATH:

County: Allegany

City or town: Cumberland

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 60 Years

Hospital, institution, or street address where death occurred:

923. Bedford St

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Allegany

City or town: Cumberland

(If outside city or town limits, write RURAL and give nearest town)

Street No. 923. Bedford St

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME: Charles Carl Daehler

3.(b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Widowed

6.(b) Name of husband or wife: Mary E. Daehler

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): November 28, 1861

8. AGE: Years	Months	Days	If less than one day
83	1	3	..... hrs. ..... min.

9. Birthplace: Pittsburgh Penna (Town, county, and state)

10. Usual occupation: Concrete Contractor

11. Industry or business: Concreteing

FATHER

12. Name: Andrew Daehler

13. Birthplace: Dadaria, Germany

MOTHER

14. Maiden name: Marga Retha Pruesendoerser

15. Birthplace: Dadaria, Germany

16. Informant: Mrs. R. D. Nave

Address: 923. Bedford St, Cumberland, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 1/3/45 (month) (day) (year)

Cemetery or crematory: Rose Hill Mausolium

Location: Cumberland, Md.

18. Funeral director: William H. Kight

Address: Cumberland, Md.

19. Jan 3, 1945 (Date rec'd by registrar) Winter L. Trautt M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Jan 1, 1945, at 4:20 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan 1, 1944, to Jan 1, 1945, and that I last saw h. l. M. alive on Dec 31, 1944

Immediate cause of death	DURATION
(a) Uremic myocarditis	1
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide. Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE: H. V. Deming M.D. M. D. or other

Address: 125 Bedford St Date signed 1-2-45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

Outside of City Limits

(M)

00621

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (170-C)

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH:
County: Allegany
City or town: Near Cumberland, Rural
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? -
Hospital, Institution, or street address where death occurred:
LaVale Boulevard
How long in hospital or institution? -

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md County: Allegany
City or town: Long, Md.
(If outside city or town limits, write RURAL and give nearest town)
Street No. LaVale Blvd. Rt. 40
(If rural, give LOCATION)
2.(a) If veteran, name war: World War No. 1.

3.(a) FULL NAME: Hampton T. Dashiell

3.(b) Social Security Number: 220-10-8952

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	W	married

6.(b) Name of husband or wife: Cora Boneser
6.(c) If alive, give age ..... years
7. Birth date of deceased (mo., day, yr.): 1894

8. AGE: Years	Months	Days	If less than one day
50			..... hrs. ..... min.

9. Birthplace: Princess Anne, Md. (Town, county, and state)
10. Usual occupation: Laborer
11. Industry or business: Celenese Corp. of America

FATHER
12. Name: Hampton Dashiell
13. Birthplace: Md.

MOTHER
14. Maiden name: Unknown
15. Birthplace: —

16. Informant: Cora B. Dashiell
Address: LaVale, Md.

17. Burial (Burial, cremation, or removal) Which?
Date thereof: Jan 31 1945 (month) (day) (year)
Cemetery or crematory: Princess Anne Cem
Location: Princess Anne

18. Funeral director: Louis Stein, Inc.
Address: Cumberland, Md

19. Jan 30 19 45 Winter R. Trantz, M.D. Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH: January 29th., 19 45, at 12.05 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ..... 19..... to ..... 19.....
and that I last saw h..... alive on ..... 19.....

Immediate cause of death: Fractured skull at base — DURATION: 10 min.
Due to: —
Due to: —
Other conditions: Fractured left tibia and fibula. (Include pregnancy within 3 months of death)

Major findings of operations: — — —
Date of op. .....
Autopsy results: no autopsy
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following: (11.55 P.M.)
Accident, suicide, or homicide: accident Date of: 1-28-45
Where did injury occur? Near Cumberland, (City or town) Allegany, (County) Md. (State)
Injured at home, farm, industry, public place (where?): highway
Means of injury: struck by car Injured at work? no

23. SIGNATURE: Chas H. Brown, M.D. M. D. or other
Address: Cumberland, Maryland Date signed: 1-29-45

Deputy Medical Examiner - Allegany Co.

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

DR. TOPPER

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (92-6)

00622

CERTIFICATE OF DEATH

Reg. Diat. No. 4

1. PLACE OF DEATH:
County Allegany
City or town Cumberland, Maryland
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred:
Memorial Hospital
How long in hospital or institution? 15 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Pennsylvania County Somerset
City or town McDonaldton
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war V

3. (a) FULL NAME
Mrs. Romaine L. Deeter

3. (b) Social Security Number
None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Married

6.(b) Name of husband or wife Earl L. Deeter
6.(c) If alive, give age 28 years
7. Birth date of deceased (mo., day, yr.) October 16, 1916

8. AGE: Years	Months	Days	If less than one day
28	2	20	hrs. min.

9. Birthplace Pennsylvania
(Town, county, and state)
10. Usual occupation Housewife
11. Industry or business
FATHER 12. Name Charles Mowry
13. Birthplace Pennsylvania
MOTHER 14. Maiden name Blanche Coughenour
15. Birthplace Pennsylvania
16. Informant Memorial Hospital
Address Cumberland, Maryland
17. Burial (Burial, cremation, or removal. Which?) Date thereof Jan 10 1945 (month) (day) (year)
Cemetery or crematory Berlin Cem
Location Berlin Pa
18. Funeral director Johnson & Son
Address Berlin Pa
19. Jan 8 1945 (Date rec'd by registrar) Winter R. Beatty, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH January 6 1945, at 9:30 P M
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 12-16 1944 to Jan 6 1945
and that I last saw h. E.R. alive on Jan 6 1945

	DURATION
Immediate cause of death Chronic Valvular Heart Disease	10 yrs.
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE John A Leppo M.D.
M. D. or other
Address Hyndman Pa Date signed 1-7-45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

00623

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH:

County: Allegany

City or town: Cumberland

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

Allegany Hospital

How long in hospital or institution? 2 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Md County: Allegany

City or town: Cumberland

(If outside city or town limits, write RURAL and give nearest town)

Street No. 138 Monroe Street

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME William B DeVore

3.(b) Social Security Number None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	W	Married

6.(b) Name of husband or wife: Armetta Hershberger

6.(c) If alive, give age: 60 years

7. Birth date of deceased (mo., day, yr.): July 30, 1873

8. AGE: Years	Months	Days	If less than one day
71	5	21	...hrs. ...min.

9. Birthplace: Pa.

(Town, county, and state)

10. Usual occupation: Grocer

11. Industry or business: Grocery Store.

FATHER

12. Name: William DeVore

13. Birthplace: Penna

MOTHER

14. Maiden name: Martha Lowry

15. Birthplace: Penna

16. Informant: John Buchanan

Address: Hyndman, Pa RD

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Jan. 24 1945 (month) (day) (year)

Cemetery or crematory: Palo Alto Cemetery

Location: Hyndman, Pa. Rural

18. Funeral director: Harvey N. Teigler

Address: Hyndman, Pa.

19. Jan 24 1945 (Date rec'd by registrar) Winter R. Frantz M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 1/21 1945 at 3:35 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan. 19 - 1945 to Jan 21 - 1945 and that I last saw him alive on Jan 21 - 1945

Immediate cause of death	DURATION
Stroke	3 days
Due to: Arter. S. Vasc. of Pancr.	
Due to	
Other conditions	

(Ioelodo pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Accident Date of: Jan 19-45

Where did injury occur? Cumberland Allegany Md.

(City or town) (County) (State)

Injured at home, farm, industry, public place (where?): At Home

Means of injury: Fall Injured at work? —

23. SIGNATURE: D.P.W. Lucas M. D. or other

Address: Cumberland Md. Date signed: 1-23-45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 18

00624

CERTIFICATE OF DEATH

Reg. Dist. No. 6

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County: Allegany

City or town: McCoole

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Allegany

City or town: McCoole

(If outside city or town limits, write RURAL and give nearest town)

Street No.: Queen St.

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME: Shirley Marie Didawick

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Single

6.(b) Name of husband or wife

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): Jan. 8, 1945

8. AGE: Years | Months | Days | If less than one day: 2 hrs. ..... min.

9. Birthplace: McCoole, Allegany Co. Md.
(Town, county, and state)

10. Usual occupation

11. Industry or business

FATHER
12. Name: Homer L. Didawick
13. Birthplace: Springfield, W.Va.

MOTHER
14. Maiden name: Mildred Whetzell
15. Birthplace: Medeley, W.Va.

16. Informant: Homer D. Didawick

Address: McCoole, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Jan. 10, 1945 (month) (day) (year)

Cemetery or crematory: Cosner Family Cemetery

Location: Bismark, W.Va.

18. Funeral director: N.L. Rogers Funeral Director

Address: Keyser, W.Va.

19. Jan 9 19 45 (Date rec'd by registrar) — Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: January 8, 1945, at 6 A. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan 8 1945 to Jan 8 1945 and that I last saw her alive on Jan 8 1945

	DURATION
Immediate cause of death: Premature	1/2 hour
Due to:	
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ..... Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury — Injured at work?

23. SIGNATURE: E.G. Courrier M.D.
M. D. or other

Address: Keyser W.Va. Date signed: 1-8-45

DR. WILLIAMS

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (13-a)

00025

CERTIFICATE OF DEATH

Reg. Dist. No. 4

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County: Allegany

City or town: Cumberland, Maryland

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 25 yrs.

Hospital, institution, or street address where death occurred: Memorial Hospital

How long in hospital or institution? 52 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Allegany

City or town: Cumberland

(If outside city or town limits, write RURAL and give nearest town)

Street No. 234 Avirett Avenue

(If rural, give LOCATION)

2.(a) If veteran, name war:

3.(a) FULL NAME: Mrs. Alice Mae Drumm

3.(b) Social Security Number: None

4. Sex	5. Color or race	8.(a) Single, married, widowed, or divorced
Female	White	Married

6.(b) Name of husband or wife: James Drumm

6.(c) If alive, give age: 53 years

7. Birth date of deceased (mo., day, yr.): August 6 1892

8. AGE: Years	Months	Days	If less than one day
52	5	18	...hrs. ...min.

9. Birthplace: Ellerslie Md (Town, county, and state)

10. Usual occupation: Housewife

11. Industry or business:

FATHER — 12. Name: George Mock

FATHER — 13. Birthplace: Pennsylvania

MOTHER — 14. Maiden name: Sarah A Snowden

MOTHER — 15. Birthplace: Pa

18. Informant: Memorial Hospital

Address: Cumberland, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Jan 27 45 (month) (day) (year)

Cemetery or crematory: Greenmount Cem

Location: Cumberland Md

18. Funeral director: Louis Stein Inc

Address: Cumberland

19. Jan. 27 1945 (Date rec'd by registrar) Winter R. Frantz, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: January 24, 1945 at 10:25 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 1-23-44 to 1-24-45

and that I last saw h alive on 1-24-45

	DURATION
Immediate cause of death: (a) Cerebral Hemorrhage	Several years
Due to: (b) Hypertension (Essential)	
Due to: (c)	
Other conditions: None	

(Include pregnancy within 3 months of death)

Major findings of operation: None

Date of op. None

Autopsy results: None

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: W. F. Williams M. D. or other

Address: Cumberland Date signed: 1-25-45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

00626

CERTIFICATE OF DEATH

Reg. Diat. No. 9

1. PLACE OF DEATH:

County: Allegany

City or town: Frostburg
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? Lifetime

Hospital, institution, or street address where death occurred:
Miners Hospital

How long in hospital or institution? 1 Day

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Allegany

City or town: Frostburg
(If ontside city or town limits, write RURAL and give nearest town)

Street No. 7 Oak Street
(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME

Flora Belle Edmondson

3.(b) Social Security Number

213-10-9882

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	Negro	Widowed

6.(b) Name of husband or wife: Enoch Edmondson

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): February 8, 1885

8. AGE: Years	Months	Days	If less than one day
59	11	12	..... hrs. ..... min.

9. Birthplace: Frostburg, Allegany Co., Md.
(Town, county, and state)

10. Usual occupation: Houseworker

11. Industry or business

FATHER
12. Name: Joseph Williams
13. Birthplace: Shaft, Maryland

MOTHER
14. Maiden name: Annabell Smith
15. Birthplace: Washington, D.C.

16. Informant: Georgiadna Hall

Address: 7 Oak Street, Frostburg, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Jan. 31, 1945 (month) (day) (year)

Cemetery or crematory: Allegany Cemetery

Location: Frostburg, Maryland

18. Funeral director: Jacob Hafer

Address: Frostburg, Maryland

19. 1-30 1945 Mrs Nancy A Roe
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: January 28 1945, at 10 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from January 25 1945, to Jan 28 1945 and that I last saw h... alive on January 28 1945

Immediate cause of death	DURATION
Acute cardiac failure	12 hrs
Due to: Acute Cholecystitis and Chr. Heart Disease	4 days
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE: Hilda Durkalter M.D.
M.D. for other

Address: Frostburg, Md Date signed: 1/28/45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (13)

00627

CERTIFICATE OF DEATH

Reg. Dist. No. 14

1. PLACE OF DEATH

County: Allegany

City or town: Ft Kleslie

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? Life

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Allegany

City or town: Ellerslie

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME Sylvester Emerick

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Widowed

6.(b) Name of husband or wife: Jannette Hardinger

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): November 26, 1856

8. AGE:

Years	Months	Days	If less than one day
88	1	21	hrs. min.

9. Birthplace: Hyndman Pa RD1 (Town, county, and state)

10. Usual occupation: Retired Railroad Engineer

11. Industry or business

FATHER 12. Name: Jacob Emerick

13. Birthplace: Penna

MOTHER 14. Maiden name: Sarah Trautman

15. Birthplace: Pa

16. Informant: Mrs. Elbert Chatain

Address: Ellerslie, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Jan 20 1945 (month) (day) (year)

Cemetery or crematory: Hyndman

Location: Hyndman

18. Funeral director: Harvey F. Zeigler

Address: Hyndman Pa

19. Jan 19 1945 (Date rec'd by registrar) J. Kloyd Wolfe Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Jan 17 1945, at 5:30 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan 1944, to Jan 17 1945

and that I last saw h/ alive on Jan 17 1945

Immediate cause of death	DURATION
Chronic arteria-Sclerotic Cardio Renal Disease	10 yrs.
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: John A Topper M.D. M. D. or other

Address: Hyndman Pa Date signed: 1-19-45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (94a)

CERTIFICATE OF DEATH

00628

Reg. Dist. No. 9

1. PLACE OF DEATH:

County Allegany

City or town Frostburg

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 3 Years

Hospital, Institution, or street address where death occurred: Miner's Hospital

How long in hospital or institution? 2 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

New York County Queens

City or town Whitestone N. Y.

(If outside city or town limits, write RURAL and give nearest town)

Street No. 40-20 Parsons Lane, S. Spring Lake

(If rural, give LOCATION)

2.(a) If veteran, name war V

3.(a) FULL NAME Walter Emrick

3.(b) Social Security Number 052-01-5628

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife Helen Emrick

6.(c) If alive, give age 36 years

7. Birth date of deceased (mo., day, yr.) June 14th. 1909

8. AGE:

Years	Months	Days	If less than one day
35	6	13	..... hrs. ..... min.

9. Birthplace Brooklyn, New York (Town, county, and state)

10. Usual occupation Vice President

11. Industry or business Manufacturing

FATHER 12. Name George W. Emrick

13. Birthplace New York

MOTHER 14. Maiden name Anna Fiss

15. Birthplace Germany

16. Informant Melvin V. Emrick

Address 82-14 167th St. Jamaica L.I.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 1-14-45 (month) (day) (year)

Cemetery or crematory Memorial Abbey, Cypress Hills

Location Brooklyn, N. Y.

18. Funeral director Jacob Kafer

Address Frostburg, Md.

19. 1-11 1945 (Date rec'd by registrar) Mrs. Nancy H. Rae Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH January 11 1945, at 6 00 (A.M.) M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan 9 1945, to Jan 11 1945 and that I last saw him alive on Jan 11 1945

Immediate cause of death	DURATION
Coronary Occlusion	48 hrs
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE H. J. Walters M.D. M. D. or other

Address Frostburg, Md. Date signed 1/11/45

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

DR. WILSON

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 170-0

CERTIFICATE OF DEATH

00629

Reg. Dist. No. 4

1. PLACE OF DEATH:
County: ALLEGANY
City or town: CUMBERLAND, MARYLAND
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 5 days
Hospital, institution, or street address where death occurred: MEMORIAL HOSPITAL
How long in hospital or institution? 5 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: WEST VIRGINIA County: MINERAL
City or town: WILEY FORD
(If outside city or town limits, write RURAL and give nearest town)
Street No.:
(If rural, give LOCATION)
2.(a) If veteran, name war: ✓

3.(a) FULL NAME: GEORGE NELSON FADLEY

3.(b) Social Security Number: None?

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
MALE	WHITE	Single

6.(b) Name of husband or wife:
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): JUNE 24 1940

8. AGE: Years	Months	Days	If less than one day
4	7	6	hrs. min.

9. Birthplace: Cumberland Md (Town, county, and state)
10. Usual occupation: ~~CHILD~~ None
11. Industry or business

FATHER — 12. Name: FRED NELSON FADLEY
13. Birthplace: WEST VIRGINIA

MOTHER — 14. Maiden name: MARY BURKHART
15. Birthplace: MARYLAND

16. Informant: Frederick R. Fadley
Address: Wileys Ford W. Va.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Feb 2 45 (month) (day) (year)
Cemetery or crematory: Ft Ashby Cem.
Location: Ft. Ashby W. Va.
18. Funeral director: Louis Stein Inc
Address: Cumberland Md

19. Feb. 1, 1945 (Date rec'd by registrar) Winter R. Frantz, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: JANUARY, 30, 1945 3:01 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan 25, 1945 to Jan 30 1945
and that I last saw him alive on Jan 29 1945
Immediate cause of death: Pneumonia & Contusion brain — DURATION: 5 days
Due to: Fall down
Due to: Auto Accident
Other conditions:
(Include pregnancy within 3 months of death)
Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: accident Date of: Jan 25, 1945
Where did injury occur? Mineral Co. (City or town) (County) W Va. (State)
Injured at home, farm, industry, public place (where?): public road
Means of injury: Auto Injured at work? —

23. SIGNATURE: F. M. Wilson M.D. (M. D. or other)
Address: Cumberland Md. Date signed: 1-30-45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

00030

Reg. Dist. No. 4

1. PLACE OF DEATH:

County Allegany

City or town Cumberland

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, Institution, or street address where death occurred:

Allegany Hospital

How long in hospital or institution? 13½ months

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Allegany

City or town Cumberland

(If ontside city or town limits, write RURAL and give nearest town)

Street No. 312 N. Mechanic St.

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME George Feldman

3.(b) Social Security Number None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	W	Married

6.(b) Name of husband or wife Margaret McCaffrey

6.(c) If alive, give age 70 years

7. Birth date of deceased (mo., day, yr.) March 20, 1870

8. AGE: Years	Months	Days	If less than one day
74	9	19	....hrs. ....min.

9. Birthplace Eckhart Allegany Maryland

(Town, county and state)

10. Usual occupation Retired - Carpenter

11. Industry or business

FATHER 12. Name Peter Feldman

13. Birthplace Germany

MOTHER 14. Maiden name Mary C. Farley

15. Birthplace Ireland

16. Informant Mrs. Albert J. Pau

Address 312 N. Mechanic St.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Jan 13 1945 (month) (day) (year)

Cemetery or crematory St. Michaels Cemetery

Location Frostburg, Md.

18. Funeral director John J. Hafer

Address Cumberland, Maryland

19. Jan 17, 1945 (Date rec'd by registrar) Walter R. Trautz M.D. Registrar

Dr. Trovaskis

MEDICAL CERTIFICATION

20. DATE OF DEATH January 9, 1945 at 8 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Nov 1st 1944 to Jan 9 1945

and that I last saw him alive on Jan 8 1945

Immediate cause of death	DURATION
Cancer of prostate	14 mos
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE R. F. Trovaskis, M.D. M. D. or other

Address Cumberland, Md. Date signed Jan 10-45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

DR. ENFIELD

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (462)

CERTIFICATE OF DEATH

00031

Reg. Diat. No. 4

M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County: Allegany
City or town: Cumberland, Maryland
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred:
Memorial Hospital
How long in hospital or institution? 16 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Pennsylvania County: Bedford
City or town: Mann's Choice
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war: ✓

3. (a) FULL NAME
Mrs. Beatrice Fletcher

3. (b) Social Security Number
None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Widowed

6.(b) Name of husband or wife: Hiram Fletcher
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): August 2, 1882

8. AGE: Years	Months	Days	If less than one day
62	5	4	hrs. min.

9. Birthplace: Delaware (Town, county, and state)
10. Usual occupation: Housewife
11. Industry or business

FATHER
12. Name: Henry Bruner
13. Birthplace: Pennsylvania

MOTHER
14. Maiden name: Cecelia Compton
15. Birthplace: Pennsylvania

16. Informant: Memorial Hospital
Address: Cumberland, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof Jan. 9 1945 (month) (day) (year)
Cemetery or crematory: Mt. Olivet Cem.
Location: Mann's Choice, Penna
18. Funeral director: Harvey H. Beigler
Address: Hyndman, Penna

19. Jan 8, 1945 (Date rec'd by registrar) Winter R. Fauth M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: January 6th 1945, at 9:45 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Dec 21 1944 to Jan 6 1945 and that I last saw h[illegible] alive on Jan 6 1945

Immediate cause of death	DURATION
Coronary Occlusion	
Due to Shock	
Due to Hemorrhage Peptic Ulcer	
Due to Carcinoma Sigmoid	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: Adenocarcinoma Sigmoid with metastasis
Date of op. 12/45
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE: S C Eichard M. D. or other
Address: Cumberland Date signed 1/6/45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

00032

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH:

County: Allegany

City or town: Cumberland.

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 30 yrs.

Hospital, institution, or street address where death occurred: Memorial Hosp.

How long in hospital or institution? 4 hrs.

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Allegany

City or town: Cumberland.

(If outside city or town limits, write RURAL and give nearest town)

Street No. 420 S. Allegany St.

(If rural, give LOCATION)

2.(a) If veteran, name war:

3.(a) FULL NAME: Ella Gaither

3.(b) Social Security Number: None

4. Sex	5. Color or race	8.(a) Single, married, widowed, or divorced
Female	White	Married

6.(b) Name of husband or wife: Herbert Gaither

6.(c) If alive, give age: ____ years

7. Birth date of deceased (mo., day, yr.): Oct 1875

8. AGE:

Years	Months	Days	If less than one day
69			____ hrs. ____ min.

9. Birthplace: Hartford Co. Md. (Town, county, and state)

10. Usual occupation: Housewife

11. Industry or business: At Home.

FATHER — 12. Name: Frank Taylor

13. Birthplace: Md.

MOTHER — 14. Maiden name: Elizabeth Tennant

15. Birthplace: Md.

16. Informant: Frank P. Gaither

Address: Cumberland.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Jan 17 45 (month) (day) (year)

Cemetery or crematory: Darlington Cem.

Location: Darlington Md.

18. Funeral director: Louis Stein Inc.

Address: Cumberland

19. Jan. 16 1945 (Date rec'd by registrar) Walter L. Hantz, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Jan 14 1945 at 3 A. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan. 13 1945 to Jan. 13 1945 and that I last saw her alive on Jan. 13 1945

Immediate cause of death	DURATION
Cerebral Hemorrhage	5 hrs.
Due to:	
Due to:	
Other conditions: Hypertension	?

(Include pregnancy within 3 months of death)

Major findings of operations: ____ Date of op. ____

Autopsy results: ____

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ____ Date of ____

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?): ____

Means of injury: ____ Injured at work?

23. SIGNATURE: James E. McLean M.D. (M. D. or other)

Address: 449 Greene St. Date signed: 1-15-45

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (93-2)

CERTIFICATE OF DEATH

00033

Reg. Diat. No. 9

1. PLACE OF DEATH:
County: Allegany
City or town: Eckhart
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, Institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Allegany
City or town: Eckhart
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME: Michael Gaudio

3.(b) Social Security Number: none

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: Rose Gaudio
6.(c) If alive, give age: 78 years

7. Birth date of deceased (mo., day, yr.): October 8, 1861

8. AGE:

Years	Months	Days	If less than one day
83	3	22	...hrs. ...min.

8. Birthplace: Celico Italy
(Town, county, and state)
10. Usual occupation: merchant
11. Industry or business: grocery business
FATHER 12. Name: Antony Gaudio
13. Birthplace: Italy
MOTHER 14. Maiden name: unknown
15. Birthplace
16. Informant: Frank Iaccino
Address: Eckhart, Md.
17. Burial (Burial, cremation, or removal. Which?) Date thereof: Feb. 1 1945 (month) (day) (year)
Cemetery or crematory: St. Michael's Cemetery
Location: Frostburg Md
18. Funeral director: J. J. Obrist
Address: Frostburg Md.
19. 1-31 1945 Mrs Nancy M. Roe
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Jan 30 1945, at 1 20 A M
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan 3 1940 to Jan 30 1945 and that I last saw him alive on Jan 26 1945

Immediate cause of death	DURATION
Chronic Myocarditis	2 yrs
Due to: Chr Bronchitis	
Due to: Senility	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operation
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide. Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE: W O'M Lane Jr MD
M. D. or other
Address: Frostburg Md. Date signed: Jan 30 1945

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

DR. WILLIAMS

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (46?)

CERTIFICATE OF DEATH

00034

Reg. Diat. No. 4

1. PLACE OF DEATH:
County: Allegany
City or town: Cumberland, Maryland
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred:
Memorial Hospital
How long in hospital or institution? 58 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Allegany
City or town: Mount Savage
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME: Mr. Charles M. Gelhausen

3. (b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: Martha Wilhelm
6.(c) If alive, give age: 75 years

7. Birth date of deceased (mo., day, yr.): March 5, 1869

8. AGE: Years	Months	Days	If less than one day
75	10	12	hrs. min.

9. Birthplace: West Virginia (Town, county, and state)
10. Usual occupation: Unable to Work
11. Industry or business

FATHER
12. Name: Nicholas Gelhausen
13. Birthplace: Unknown

MOTHER
14. Maiden name: Pauline Bosley
15. Birthplace: West Virginia

16. Informant: Memorial Hospital
Address: Cumberland, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof Jan. 19 1945 (month) (day) (year)
Cemetery or crematory: Rose Hill
Location: Thomas, W.Va.
18. Funeral director: H. D. Duncan
Address: Thomas, W.Va.
19. Jan. 19 1945 (Date rec'd by registrar) Winter R. Frantz, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: January 17, 1945, at 5:40A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Nov. 20 1944 to 1-17-1945 and that I last saw him alive on 1-16-1945

Immediate cause of death	DURATION
Carcinoma	?
Due to: of Stomach	-
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: Sub Resection of Stomach Date of op. 11-27-44
Autopsy results: None
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: W. F. Williams M. D. or Other
Address: Cumberland Date signed 1-17-45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

DR. ELIASON

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (83-a)

00035

CERTIFICATE OF DEATH

Reg. Diat. No. 4

1. PLACE OF DEATH:
County ALLEGANY
City or town CUMBERLAND, MARYLAND
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred: Memorial Hospital
How long in hospital or institution? 14 DAYS

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State MARYLAND County ALLEGANY
City or town Near CUMBERLAND, MD. Rural
(If outside city or town limits, write RURAL and give nearest town)
Street No. R. # 2, Baltimore Pike
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME EMILY SUSAN GOLDEN

3. (b) Social Security Number None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
FEMALE	WHITE	WIDOWED

6.(b) Name of husband or wife JAMES H. GOLDEN
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) SEPT. 26, 1867

8. AGE:

Years	Months	Days	If less than one day
77	3	11	..... hrs. ..... min.

9. Birthplace Martinsburg West Virginia (Town, county, and state)
10. Usual occupation Housewife
11. Industry or business

FATHER
12. Name HORN, Henry H.
13. Birthplace W.VA., Martinsburg

MOTHER
14. Maiden name RIDENOUR, FRANCIS VIRGINIA
15. Birthplace W.VA., Martinsburg

16. Informant Chas. Golden
Address 243 Williams St., Cumberland

17. Burial (Burial, cremation, or removal. Which?) Date thereof Jan. 9, 1945 (month) (day) (year)
Cemetery or crematory Greenmount Cem.
Location Cumberland, Md.

18. Funeral director John J. Hafer
Address Cumberland, Md.

19. Jan. 8, 1945 (Date rec'd by registrar) Wm. R. Beasley, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 1-7-45 at 10:30 M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ..... 19..... to ..... 19.....
and that I last saw h..... alive on ..... 19.....

Immediate cause of death	DURATION
Cerebral Hemorrhage	
Due to Arteriosclerosis	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE H. H. Pearsall M. D. or other
Address 136 Decatur St. Cumberland Date signed 1/7/45

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

Evidence for change of cause of death is shown on FILM No. G 9 4 MAY 16 1945

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

00036

Reg. Dist. No. 4

1. PLACE OF DEATH:

County: Allegany

City or town: Cumberland
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 4 days

Hospital, institution, or street address where death occurred:
Allegany Hospital

How long in hospital or institution? 4 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Md. County: Allegany

City or town: R.D. #2 Cumberland Rural
(If outside city or town limits, write RURAL and give nearest town)

Street No.: Williams Rd. Rt. #2
(If rural, give LOCATION)

2.(a) If veteran, name war:

3.(a) FULL NAME Laura "Swisher"
Anna A Harman

3.(b) Social Security Number None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Married

6.(b) Name of husband or wife: Owen Harman

6.(c) If alive, give age: 54 years

7. Birth date of deceased (mo., day, yr.): June 19, 1895

8. AGE: Years	Months	Days	If less than one day
49	7	10	...hrs. ...min.

9. Birthplace: Virginia Staunton, Hampshire
(Town, county, and state)

10. Usual occupation: Housewife

11. Industry or business: Own home

FATHER
12. Name: Taylor Swickes Swisher
13. Birthplace: Hampshire Co., W. Va.

MOTHER
14. Maiden name: Lettie Swisher
15. Birthplace: Augusta Co. Va

16. Informant: Owen Harman
Address: Route 7, Cumberland, Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Jan 31 1945 (month) (day) (year)
Cemetery or crematory: Barry Cemetery
Location: Town Creek, Md.

18. Funeral director: John J. Hafer
Address: Cumberland, Md.

19. Jan. 30 1945 (Date rec'd by registrar) Winter R. Trantz M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 1/29/45 1/29 1945, at 12:30 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 1/24 1945 to 1/29/45 1945 and that I last saw her alive on 1/29/45 1945

Immediate cause of death	DURATION
Shock following	
Due to: Hysterectomy 3 days. Fibroid uterus, abscessed tubes	Several years.
Due to: many dense adhesions c.w.s.B.	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ...Date of op. ...

Autopsy results: ~

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ~ Date of ...

Where did injury occur? ~ (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) ~

Means of injury ... Injured at work?

23. SIGNATURE: E Kester M. D. or other

Address: 122 Bedford St Date signed: 1/29/45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS/A15

DR. ELIASON

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (92-d)

CERTIFICATE OF DEATH

00037

Reg. Dist. No. 4

1. PLACE OF DEATH:
County: Allegany
City or town: Cumberland, Maryland
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 20 yrs
Hospital, Institution, or street address where death occurred:
Memorial Hospital
How long in hospital or institution? 3 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Allegany
City or town: Cumberland
(If outside city or town limits, write RURAL and give nearest town)
Street No. 310 Race Street
(If rural, give LOCATION)
2.(a) If veteran, name war:

3. (a) FULL NAME
Rev. Leighton B. Hensley

3. (b) Social Security Number
None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: Bertie Collett
6.(c) If alive, give age: 72 years

7. Birth date of deceased (mo., day, yr.): June 14, 1879

8. AGE: Years	Months	Days	If less than one day: hrs.	min.
65	6	19		

9. Birthplace: Gonzales, Texas (Town, county, and state)
10. Usual occupation: Minister
11. Industry or business

FATHER
12. Name: Phillip Hensley
13. Birthplace: Texas

MOTHER
14. Maiden name: Mary Beaumont
15. Birthplace: Texas

16. Informant: Memorial Hospital
Address: Cumberland, Maryland

17. Removal to Burial (Burial, cremation, or removal. Which?) Date thereof: Jan 4 - 45 (month) (day) (year)
Cemetery or crematory: Elkins Mem.
Location: Elkins W. Va.
18. Funeral director: Louis Stein Inc
Address: Cumberland Md
19. Jan. 3, 1945 (Date rec'd by registrar) Walter L. Trautman M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: January 3 19 45 at 12:50A M

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from 1-1 19 45, to 1-3 19 45
and that I last saw h... alive on 1-2 19 45

	DURATION
Immediate cause of death: Chronic Myocarditis.	3 yr
Chronic Valvular Disease.	5 yr
Due to: Arteriosclerosis	10 yr
Due to:	
Other conditions: Acute Cold	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of:
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?):
Means of injury: Injured at work?

23. SIGNATURE: H. L. Eliason M.D.
M. D. or other
Address: 136 Vincent St. Cumberland Md Date signed: 1/8/45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (74a)

00638

CERTIFICATE OF DEATH

Reg. Diat. No. 4

1. PLACE OF DEATH:
County: Allegany
City or town: Cumberland
(If ontside city or town limits, write RURAL and give nearest town)
How long in above place of death? 10 yrs.
Hospital, institution, or street address where death occurred:
218 Columbia St.
How long in hospital or institution? ✓

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Allegany
City or town: Cumberland
(If outside city or town limits, write RURAL and give nearest town)
Street No. 218 Columbia St.
(If rural, give LOCATION)
2.(a) If veteran, name war:

3. (a) FULL NAME Edgar Ewell Higgins

3. (b) Social Security Number NONE

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Widowed

6.(b) Name of husband or wife: Marie Smith
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): March 4 1876

8. AGE: Years	Months	Days	If less than one day
69	10	20	hrs. min.

9. Birthplace: Virginia (Town, county, and state)
10. Usual occupation: Beauty Shop operator
11. Industry or business:
12. FATHER Name: Joseph Higgins
13. Birthplace: Virginia
14. MOTHER Maiden name: Ella Anderson
15. Birthplace: Virginia
16. Informant: Stanley Higgins
Address: Cumberland, Md.
17. Burial (Burial, cremation, or removal. Which?) Date thereof: Jan 28 1945 (month) (day) (year)
Cemetery or crematory: Richmond Cem.
Location: Richmond, Virginia
18. Funeral director: Louis Stein, Inc.
Address: Cumberland, Md
19. Jan. 26 1945 (Date rec'd by registrar) Hunter R. Trantz, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: January 24th., 1945, at 11:45 A.M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ..... 19..... to ..... 19.....
and that I last saw h..... alive on ..... 19.....

Immediate cause of death	DURATION
Coronary Occlusion	
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ---
Date of op.:
Autopsy results: no autopsy
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of:
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?):
Means of injury: Injured at work?

23. SIGNATURE: Pierce H. Dotson, M.D. (M. D. or other)
Address: Cumberland, Maryland Date signed: 1-24-45
Deputy Medical Examiner - Allegany Co.

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (159)

CERTIFICATE OF DEATH

00039

Reg. Dist. No. 4

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County: Allegany

City or town: Cumberland
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:
Allegany Hospital

How long in hospital or institution? 7 hrs

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Md. County: Allegany

City or town: Cumberland
(If outside city or town limits, write RURAL and give nearest town)

Street No. 317 Magruder St
(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME: Baby Boy Hinea

3.(b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	W	S

6.(b) Name of husband or wife

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): January 14, 1945

8. AGE: Years | Months | Days | If less than one day: 7 hrs. 42 min.

9. Birthplace: Md - Cumberland, Allegany Co.
(Town, county, and state)

10. Usual occupation

11. Industry or business

FATHER
12. Name: Charles Hinea
13. Birthplace: Pa

MOTHER
14. Maiden name: Nancy Moore
15. Birthplace: W. Va.

16. Informant: Charles Hinea

Address: Cumberland Md.

17. Burial (Burial, cremation, or removal) Which? Date thereof: Jan 15 45 (month) (day) (year)

Cemetery or crematory: St P.O.P. Cem.

Location: Cumberland Md

18. Funeral director: Louis Stern Sec.

Address: Cumberland Md

19. Jan. 15, 1945 (Date rec'd by registrar) Walter R. Beatty M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 1/14, 1945, at 7:30 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan. 14, 1945 to Jan. 14, 1945 and that I last saw h[illegible] alive on Jan. 14, 1945.

Immediate cause of death	DURATION
Premature 30 wks -	
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide. Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury. Injured at work?

23. SIGNATURE: Clay L. Timmons M. D. or other

Address: Cumberland 1-14-45 Date signed

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (193-a)

00040

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH:
County Allegany
City or town Cumberland
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred:
Allegany Hospital
How long in hospital or institution? 6 Days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Allegany
City or town Mount Savage, Maryland
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME Mrs. Alice Housel

3.(b) Social Security Number None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Married

6.(b) Name of husband or wife Clarence Housel
~~August 6, 1908~~ 6.(c) If alive, give age 37 years
7. Birth date of deceased (mo., day, yr.) August 5, 1908

8. AGE: Years	Months	Days	If less than one day
36	5	12	...hrs. ...min.

9. Birthplace Mt. Savage, Pa. (Town, county, and state)
10. Usual occupation Housewife
11. Industry or business
FATHER 12. Name Abram Gordon
13. Birthplace Maryland
MOTHER 14. Maiden name Cecelia Hooker
15. Birthplace Maryland
16. Informant Clarence Housel
Address Mt. Savage, Md.
17. Burial (Burial, cremation, or removal. Which?) Date thereof Jan. 21, 1945 (month) (day) (year)
Cemetery or crematory Methodist
Location Mt. Savage, Md.
18. Funeral director Harvey H. Zeigler
Address Frostburg, Md.
19. Jan. 20, 1945 (Date rec'd by registrar) Winter R. Beatty M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH January 17, 1945 at 6:10 P. M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan 1944 to Jan 1945
and that I last saw h... alive on Jan 17 1945

Immediate cause of death	DURATION
Acute dilatation of heart	12 hours
Due to, or as a consequence of: Strain following Enema	
Due to:	
Other conditions: Chronic Pyelonephritis	1 year

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE H. Clay Cunningham M. D. or other
Address Cumberland Md. Date signed Jan 18 45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (107)

00041

CERTIFICATE OF DEATH

Reg. Diat. No. 4

1. PLACE OF DEATH:
County: Allegany
City or town: Cumberland
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred: 311 Paca St.
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Allegany
City or town: Cumberland
(If outside city or town limits, write RURAL and give nearest town)
Street No. 311 Paca St.
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME: Mary Alice Judy

3. (b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Widowed

6.(b) Name of husband or wife: George Judy
8.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Nov. 19, 1867

8. AGE: Years	Months	Days	If less than one day
77	1	15	hrs. min.

8. Birthplace: Pendleton Co. W. Va.
(Town, county, and state)
10. Usual occupation: Housewife
11. Industry or business

FATHER
12. Name: John Harmon
13. Birthplace: W. Va.

MOTHER
14. Maiden name: Cynthia Hedrick
15. Birthplace: W. Va.

16. Informant: Mrs. Catherine Rice
Address: 311 Paca St. Cumberland, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Jan. 6 1945 (month) (day) (year)
Cemetery or crematory: Rose Hill Cem.
Location: Cumberland, Md.

18. Funeral director: Charles L. George
Address: Cumberland, Md.

19. Jan. 6, 1945 (Date rec'd by registrar) Walter R. Krantz, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Jan. 3, 1945, at 1:15 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 12-22, 1944, to 1-3-1945 and that I last saw h alive on 12-30, 1944

Immediate cause of death	DURATION
Bronchopneumonia	
Due to	
Due to	
Other conditions Arteriosclerosis	

(Include pregnancy within 3 months of death)

Major findings of operations: none
Date of op. none
Autopsy results: none
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE: W. F. Williams M. D. or Coroner
Address: Cumberland Date signed 1-5-45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

Evidence for change of birth date of deceased is shown on 83-a

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

00042

Reg. Diat. No. 4

FILM No. G 94 MAY 14 1945

1. PLACE OF DEATH:

County: Allegany

City or town: Cumberland

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 74 yrs.

Hospital, Institution, or street address where death occurred: 129 Arch St.

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Allegany

City or town: Cumberland

(If outside city or town limits, write RURAL and give nearest town)

Street No. 129 Arch St.

(If rural, give LOCATION)

2.(a) If veteran, name war: —

3.(a) FULL NAME: Robert Kelley

3.(b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: Alice Bowser

6.(c) If alive, give age: ____ years

7. Birth date of deceased (mo., day, yr.): July 30 1870

8. AGE:

Years	Months	Days	If less than one day
74	6	1	____ hrs. ____ min.

9. Birthplace: Cumberland Md (Town, county, and state)

10. Usual occupation: Ex Fireman (Retired)

11. Industry or business

FATHER

12. Name: Peter Kelley

13. Birthplace

MOTHER

14. Maiden name: Brantle

15. Birthplace

16. Informant: Mrs Alice Kelley

Address: Cumberland

17. Burial. (Burial, cremation, or removal. Which?) Date thereof Jan 3 45 (month) (day) (year)

Cemetery or crematory: Rose Hill Cem.

Location: Cumberland

18. Funeral director: Louis Stein Inc

Address: Cumberland

19. Jan 3 1945 (Date rec'd by registrar) Walter R Frantz M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Jan 1 1945 at 1:45 A M

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from Aug 15 1944 to Jan 1 1945 and that I last saw him alive on Dec 31 1944

Immediate cause of death	DURATION
Cerebral Apoplexy	2 Yrs
Due to: Arteriosclerosis	4 Yrs
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ____ Date of op. ____

Autopsy results: ____

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ____ Date of ____

Where did injury occur? ____ (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) ____

Means of injury: ____ Injured at work?

23. SIGNATURE: M E B Owens M.D. M. D. or other

Address: 132 Va Ave Date signed 1-2-45

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

00043

CERTIFICATE OF DEATH

Reg. Diat. No. 4

1. PLACE OF DEATH:

County: Allegany

City or town: Cumberland

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 22 Days

Hospital, institution, or street address where death occurred: Allegany Hospital

How long in hospital or institution? 22 Days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Penna. County: Allegheny

City or town: McKeesport

(If outside city or town limits, write RURAL and give nearest town)

Street No. 633 North Grandview

(If rural, give LOCATION)

2.(a) If veteran, name war: V

3. (a) FULL NAME: Amanda Kurtz

3. (b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Widow

6.(b) Name of husband or wife: B. F. Kurtz

6.(c) If alive, give age: ..... years

7. Birth date of deceased (mo., day, yr.): August 5 1859

8. AGE: Years	Months	Days	If less than one day
85	5	27	..... hrs. ..... min.

9. Birthplace: Mt. Savage, Allegany Co, Maryland (Town, county, and state)

10. Usual occupation: House Wife

11. Industry or business: Own House

FATHER — 12. Name: August Hildebrandt

FATHER — 13. Birthplace: Germany

MOTHER — 14. Maiden name: Willhelmina Unknown

MOTHER — 15. Birthplace: Germany

16. Informant: Robert Kurtz

Address: 633 North Grandview, McKeesport, Pa

17. Burial (Burial, cremation, or removal. Which?) Date thereof 1/5/45 (month) (day) (year)

Cemetery or crematory: Versailles Cemetery

Location: McKeesport, Pa.

18. Funeral director: William H. Kight

Address: Cumberland, Md.

19. Jan 3 1945 (Date rec'd by registrar) Winter R. Frantz, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Jan 2 1945, at 6.40 P M

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from Dec 10 1944, to Jan 2 1945

and that I last saw h..... alive on ..... 19..

Immediate cause of death	DURATION
Toxemia	about 20 days
Due to: Nephritis [illegible]	22 days
Due to: Cystitis	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....

Autopsy results: .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE: W. V. Denny M.D. M. D. or other

Address: 125 Bedford St Date signed 1-2-45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (830)

CERTIFICATE OF DEATH

00644

Reg. Dist. No. 8

1. PLACE OF DEATH:
County: Allegany
City or town: Lonaconing, Md
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred: —
How long in hospital or institution? —

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Allegany
City or town: Lonaconing
(If outside city or town limits, write RURAL and give nearest town)
Street No. —
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME: Elizabeth Judson Lane

3. (b) Social Security Number: —

4. Sex: Female
5. Color or race: White
6.(a) Single, married, widowed, or divorced: Widowed
6.(b) Name of husband or wife: Robert Lane
6.(c) If alive, give age ..... years
7. Birth date of deceased (mo., day, yr.): Oct. 31st 1857
8. AGE: Years: 87 Months: 2 Days: 28 If less than one day ..... hrs. ..... min.
9. Birthplace: Lonetown, Allegany, Md (Town, county, and state)
10. Usual occupation: Housework
11. Industry or business
FATHER 12. Name: Wm Jackson
13. Birthplace: Unknown
MOTHER 14. Maiden name: Margaret Loar
15. Birthplace: Unknown
16. Informant: Mrs Harry Lane
Address: Lonaconing, Md
17. Burial (Burial, cremation, or removal. Which?) Date thereof Jan 31 1945 (month) (day) (year)
Cemetery or crematory: Laurel Hill Cemetery
Location: Moscow, Md
18. Funeral director: M. Eichhorn
Address: Lonaconing, Md
19. Jan. 31 1945 (Date rec'd by registrar) [illegible] Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Jan. 29th 1945, at 11:30 P.M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan 27 1945, to Jan 29 1945 and that I last saw h.r alive on Jan 29 1945

	DURATION
Immediate cause of death: Cerebral Hemorrhage	
Due to:	
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: Henry M. Hodgson M.D. M. D. or other
Address: Lonaconing, Md Date signed Jan. 31 1945

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (1634)

00045

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH:

County Allegany

City or town Cumberland. (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 1½ yrs.

Hospital, Institution, or street address where death occurred 207 N. Smallwood St.

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)

State Pa. County Westmoreland

City or town Scottdale (If outside city or town limits, write RURAL and give nearest town)

Street No. 720 George St. (If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME James Smith Fautz

3.(b) Social Security Number 201-18-7083

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Single

6.(b) Name of husband or wife

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) Nov 17 1926

8. AGE: Years 18 | Months 2 | Days 14 | If less than one day ..... hrs. ..... min.

9. Birthplace Mt Pleasant, Westmoreland Co. Pa. (Town, county, and state)

10. Usual occupation Machinist Helper

11. Industry or business B & O Railroad.

FATHER 12. Name James S. Fautz.

FATHER 13. Birthplace Garrett Co. Md.

MOTHER 14. Maiden name Bessie Smith.

MOTHER 15. Birthplace Garrett Co. Md.

16. Informant James S. Fautz.

Address 207 N. Smallwood St City

17. Burial (Burial, cremation, or removal. Which?) Date thereof Feb 3, 1945 (month) (day) (year)

Cemetery or crematory Green Ridge Cemetery

Location Near Connellsville, Pa.

18. Funeral director John J. Hafer.

Address Cumberland Md

19. Feb. 3 1945 (Date rec'd by registrar) Hunter R. Frantz, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH January 31 1945 at about 2:30 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ..... 19..... to ..... 19.....

and that I last saw h..... alive on ..... 19.....

Immediate cause of death	DURATION
Suicide by Poisoning	
(Chloroform, internally)	
Due to (estimated two ounces)	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations ..... Date of op. .....

Autopsy results no autopsy

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide suicide Date of 1-31-45

Where did injury occur? Cumberland, Allegany, Md. (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) home

Means of injury poisoning Injured at work? no

23. SIGNATURE Hunter R. Frantz M.D. M. D. or other

Address Cumberland, Maryland Date signed 2-2-45

Deputy Medical Examiner - Allegany Co.

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 92d

00046

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH:
County Allegany
City or town Cumberland
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? ~ 30 yrs.
Hospital, Institution, or street address where death occurred: 100 Independence St.
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Md. County Allegany
City or town Cumberland
(If outside city or town limits, write RURAL and give nearest town)
Street No. 100 Independence St.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME Lorenzo Dow Lashley

3.(b) Social Security Number 220-10-1403

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	White	married

6.(b) Name of husband or wife Annie Schriver
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) June 22 1876

8. AGE: Years	Months	Days	If less than one day
68	7	7	..... hrs. ..... min.

9. Birthplace Buck Valley, Penna (Town, county, and state)
10. Usual occupation Spinner
11. Industry or business Celanese Corp. of America
FATHER 12. Name Wm. P. Lashley
13. Birthplace Pa.
MOTHER 14. Maiden name Harriet Northcraft
15. Birthplace Pa.
16. Informant Walter Lashley
Address Cumberland, Md.
17. Burial (Burial, cremation, or removal. Which?) Date thereof Feb 1 45 (month) (day) (year)
Cemetery or crematory Rolleresa Cem.
Location Cumberland
18. Funeral director Louis Stein Inc
Address Cumberland.
19. Feb. 1 1945 (Date rec'd by registrar) Walter R. Brantz M Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH January 29 1945, at 10:30 a.m. P.M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Dec 28 1944, to Jan 29 1945
and that I last saw h... alive on Jan 29 1945

Immediate cause of death	DURATION
Asphyxia,	
Due to pneumonia,	
Due to endocarditis	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide No Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

20. SIGNATURE W. S. Bowers M. D. or other
Address 133 Va Ave Date signed 1/3/45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (186a)

CERTIFICATE OF DEATH

00047

Reg. Dist. No. 4

1. PLACE OF DEATH:
County ALLEGANY
City or town CUMBERLAND
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred:
MEMORIAL HOSPITAL
How long in hospital or institution? 6 DAYS

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State MARYLAND County ALLEGANY
City or town CUMBERLAND
(If outside city or town limits, write RURAL and give nearest town)
Street No. 10 EAST FIRST STREET
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME
MRS. IDA LAURENT

3. (b) Social Security Number
None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
FEMALE	WHITE	MARRIED

6.(b) Name of husband or wife JULIAN LAURENT
6.(c) If alive, give age 86 years

7. Birth date of deceased (mo., day, yr.) FEBRUARY 23 1865

8. AGE:

Years	Months	Days	If less than one day
79	11	9	hrs. min.

9. Birthplace WIRGINIA
(Town, county, and state)

10. Usual occupation HOUSEWIFE

11. Industry or business

FATHER
12. Name ABRAHAM RITCHEY - DECEASED
13. Birthplace VIRGINIA

MOTHER
14. Maiden name SARAH HOOVER - DECEASED
15. Birthplace VIRGINIA

16. Informant MEMORIAL HOSPITAL
Address CUMBERLAND, MD.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Jan 4 1945 (month) (day) (year)
Cemetery or crematory Hillcrest Burial Park
Location Cumberland, Md.

18. Funeral director Louis Stein, Inc.
Address Cumberland, Md.

19. Jan 3 1945 (Date rec'd by registrar) Winter R. Beanty M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH JANUARY 1 1945 at 8:10 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Dec. 26, 1944, to Jan. 1, 1945
and that I last saw h[illegible] alive on Dec 31, 1944

	DURATION
Immediate cause of death: I was there night Pneumonia. Coronary Thrombosis.	4 days
Due to:	4 days
Due to:	
Other conditions: Bronchial pneumonia	2 days

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Accident Date of 12-26-44
Where did injury occur? Cumberland (City or town) Allegany (County) Maryland (State)
Injured at home, farm, industry, public place (where?) Home
Means of injury Fell down steps Injured at work? no.

23. SIGNATURE D R Orme M.D.
M. D. or other
Address Medical Bldg. Date signed 1-2-45.

DR. GROVE

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

Outside of City Limits

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 830

CERTIFICATE OF DEATH

00048

Reg. Diat. No. 4

1. PLACE OF DEATH:

County Allegany

City or town Cumberland (Rural)
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred: Williams Rd. RFD # 2

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Maryland County Allegany

City or town Oldtown (Rural)
(If outside city or town limits, write RURAL and give nearest town)

Street No.
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME Elizabeth H. Lewis.

3. (b) Social Security Number None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Married

6.(b) Name of husband or wife Jacob M. Lewis

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) Jan 17 1877

8. AGE: Years	Months	Days	If less than one day
67	10	3	..... hrs. ..... min.

9. Birthplace Broadfield W. Va.
(Town, county, and state)

10. Usual occupation Housewife

11. Industry or business

FATHER 12. Name James Vandersteel

13. Birthplace W. Va.

MOTHER 14. Maiden name Swan

15. Birthplace W. Va.

16. Informant Edgar T. Lewis

Address Williams Rd. RFD # 2

17. Burial (Burial, cremation, or removal. Which?) Date thereof Jan 23 45 (month) (day) (year)

Cemetery or crematory St. Hermans Cem.

Location Rural Cumberland Md

18. Funeral director Louis Stein Inc

Address Cumberland

19. Jan 23, 19 45 Walter R. Beauty M.D.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan 20 1945 at 10:40 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan 15 1945 to Jan 20 1945 and that I last saw her alive on Jan 19 1945

Immediate cause of death	DURATION
a Apoplexy	
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations ..... Date of op. .....

Autopsy results .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE T. Bailey Hunter M.D.
M. D. or other

Address Cumberland Md. Date signed 1/23/45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (122-6)

00049

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH:
County ALLEGANY
City or town CUMBERLAND, MARYLAND
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred: Memorial Hospital
How long in hospital or institution? 24 DAYS

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State W. VA. County
City or town TERRA ALTA
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war ✓

3.(a) FULL NAME NORA J. LINGER

3.(b) Social Security Number None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
FEMALE	WHITE	MARRIED

B.(b) Name of husband or wife CHARLES LINGER
B.(c) If alive, give age 67 years

7. Birth date of deceased (mo., day, yr.) JAN. 31, 1873

8. AGE: Years	Months	Days	If less than one day
71	11	3	hrs. min.

9. Birthplace WEST VIRGINIA (Town, county, and state)
10. Usual occupation HWFE
11. Industry or business
12. FATHER Name J.N. RINGER
13. Birthplace WEST VIRGINIA
14. MOTHER Maiden name HARRIET GRIBBLE
15. Birthplace WEST VIRGINIA
16. Informant MEMORIAL HOSPITAL
Address CUMBERLAND, MARYLAND
17. Burial (Burial, cremation, or removal? Which?) Date thereof Jan. 6, 1945 (month) (day) (year)
Cemetery or crematory Terra Alta Cem
Location Terra Alta W. Va.
18. Funeral director Prentiss Allaman
Address Terra Alta W. Va.
19. Jan 5 1945 (Date rec'd by registrar) Winter R. Hauntz M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH JAN. 4, 1945 at 12:54A M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from December 26, 1944 to Jan. 4, 1945 and that I last saw h.er alive on Jan 3. 1945

Immediate cause of death	DURATION
Cerebral Hemorrhage	Unknown
Due to Arteriosclerosis	
Due to Existing bowel probably not malignant.	
Other conditions Obstruction, Ileus Exteriorized	

(Ioelode pregnancy within 3 months of death)

Major findings of operation Laparotomy 45
Date of op. 12-27-

Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE A. H. Hawkins M. D. or other
Address Cumberland Md Date signed 1-4-45

VS A15 PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly. MARGIN RESERVED FOR BINDING

Outside of City limits

(M)

00050

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (94a)

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH:

County: Allegany

City or town: Near Oldtown Rural

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred: Enroute to Hospital - Oldtown Road

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Allegany

City or town: Near Oldtown Rural

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME: Anna Martha Malcolm

3.(b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Married

6.(b) Name of husband or wife: Melvin Malcolm

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): June 14 1905

8. AGE: Years	Months	Days	If less than one day
39	6	18	hrs. min.

9. Birthplace: WVa (Town, county, and state)

10. Usual occupation: Housework

11. Industry or business: Home

FATHER

12. Name: James H. Hartman

13. Birthplace: WVa

MOTHER

14. Maiden name: Martha Rader

15. Birthplace: WVa.

16. Informant: Melvin Malcolm

Address: Oldtown Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Jan 5 1945 (month) (day) (year)

Cemetery or crematory: Wesley Chapel

Location: Hampshire Co WVa.

18. Funeral director: Louis Fleming Sons

Address: Cumberland Md

19. Jan. 4 1945 Walter R. Hartz, M.D. (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION about

20. DATE OF DEATH: January 2nd., 1945, at 1:50 A. M.

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from ..... 19..... to ..... 19.....

and that I last saw h ..... alive on ..... 19.....

Immediate cause of death	DURATION
Coronary Thrombosis	
Due to	
Due to	
Other conditions	

(Incinde pregnancy within 3 months of death)

Major findings of operations: ---

Date of op.

Autopsy results: no autopsy

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: Louis H. Larson, M.D.

Address: Cumberland, Maryland M. D. or other

Date signed: 1-2-45

Deputy Medical Examiner - Allegany Co.

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (937)

CERTIFICATE OF DEATH

00051

Reg. Diat. No. 4

1. PLACE OF DEATH:

County: Allegany

City or town: Cumberland
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 14 months

Hospital, institution, or street address where death occurred:
457 Goethe St.

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Allegany

City or town: Mt. Savage
(If outside city or town limits, write RURAL and give nearest town)

Street No.
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME: Miss Leah Priscilla Mallin

3. (b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F	W	Single

6.(b) Name of husband or wife

6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.): December 27, 1860

8. AGE:

Years	Months	Days	If less than one day
84	0	17	hrs. min.

9. Birthplace: Mt. Savage, Allegany, Maryland
(Town, county and state)

10. Usual occupation: House keeper

11. Industry or business: Own home

FATHER
12. Name: Benjamin Mallin
13. Birthplace: England

MOTHER
14. Maiden name: Elizabeth Timmons
15. Birthplace: England

16. Informant: Mrs. Thomas Dunlap

Address: 457 Goethe St.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Jan. 16, 1945 (month) (day) (year)

Cemetery or crematory: St. George Episcopal Cemetery

Location: Mt. Savage, Maryland

18. Funeral director: John T. Hafer

Address: 230 Baltimore St. Cumberland Md

19. Jan. 15, 1945 (Date rec'd by registrar) Walter R. Beauty M.D. Registrar

Dr. Murray.

MEDICAL CERTIFICATION

20. DATE OF DEATH: January 14, 1945, at 11:30 P.M.

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from Jan 1943, to Jan 14 1945 and that I last saw h[illegible] alive on Dec 1944

Immediate cause of death	DURATION
Hypertension Heart Disease	2 years
Due to: Acute Dilatation of Heart	1 day
Due to:	
Other conditions: Chronic arthritis	many years

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE: A. Allen G. Murray M.D.
M. D. or other

Address: Cumberland Md Date signed: Jan 15 1945

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (21)

00052

CERTIFICATE OF DEATH

Reg. Diat. No. 4

1. PLACE OF DEATH:

County Allegany

City or town Cumberland

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

Allegany Hospital

How long in hospital or institution? 9 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md. County Allegany

City or town Cumberland

(If outside city or town limits, write RURAL and give nearest town)

Street No. 638 Columbia ave

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME Mrs Eunice Matilda Martin

3.(b) Social Security Number None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Widowed

6.(b) Name of husband or wife Andrew Martin

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) Dec 27, 1865

8. AGE:

Years	Months	Days	If less than one day
79	0	26	..... hrs. ..... min.

9. Birthplace Frostburg, Allegany Co., Md (Town, county, and state)

10. Usual occupation Housework

11. Industry or business at Home

FATHER

12. Name George Humbertson

13. Birthplace Frostburg, Md

MOTHER

14. Maiden name Marietta Bateman

15. Birthplace Frostburg, Md.

18. Informant Phillip Martin

Address 638 Columbia ave

17. Burial (Burial, cremation, or removal. Which?) Date thereof Jan 26 1945 (month) (day) (year)

Cemetery or crematory St. Patricks Cemetery

Location Cumberland, Md

18. Funeral director John J Hafer

Address Cumberland, Md.

19. Jan 25 1945 (Date rec'd by registrar) Wirter K. Frantz, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH January 23 1945 at 9:07 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan. 13 1945 to Jan. 23 1945 and that I last saw h.. alive on Jan. 23 1945

Immediate cause of death	DURATION
Diabetes Mellitus	?
Uraemia	
Due to	
Due to	
Other conditions Senility, Chr Myocarditis	?

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE James E. McLean M.D. M. D. or other

Address Keyser W Va Date signed 1-25-45

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (740)

CERTIFICATE OF DEATH

00053

Reg. Diat. No. 4

1. PLACE OF DEATH:

County Allegany

City or town Cumberland
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 70 yrs.

Hospital, Institution, or street address where death occurred:
43 Virginia Ave.

How long in hospital or institution? —

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Md. County Allegany

City or town Cumberland
(If outside city or town limits, write RURAL and give nearest town)

Street No. 32 Boone St.
(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME William M. McCormick

3.(b) Social Security Number 705-05-5227

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife Louise M. Horchler

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) Oct. 26 1874

8. AGE: Years	Months	Days	If less than one day
70	2	13	..... hrs. ..... min.

9. Birthplace Cumberland, Md.
(Town, county, and state)

10. Usual occupation Machinist Retired. 10 yrs.

11. Industry or business Rail Road Co.

FATHER
12. Name John MC Cormick
13. Birthplace Dont know

MOTHER
14. Maiden name Barbara Zink
15. Birthplace Dont know

16. Informant Mrs Louise M. Mc Cormick
Address Cumberland, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 1-11-45 (month) (day) (year)

Cemetery or crematory Hillcrest Burial Park

Location Cumberland, Md.

18. Funeral director Louis Stein Inc.
Address Cumberland, Md.

19. Jan 11, 1945 (Date rec'd by registrar) Winter R. Trautz M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH January 9th., 1945, at 10:40 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ..... 19..... to ..... 19.....

and that I last saw h..... alive on ..... 19.....

Immediate cause of death Coronary Occlusion — DURATION .....

Due to ..... DURATION .....

Due to ..... DURATION .....

Other conditions ..... DURATION .....

(Include pregnancy within 3 months of death)

Major findings of operations ..... Date of op. .....

Autopsy results no autopsy

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE Prince H. Bowman M.D. M. D. or other

Address Cumberland, Maryland Date signed 1-9-45

Deputy Medical Examiner - Allegany Co.

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (131-0)

00054

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH:

County: Allegany

City or town: Cumberland
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:
455 Columbia St.

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Md County: Allegany

City or town: Cumberland
(If outside city or town limits, write RURAL and give nearest town)

Street No. 455 Columbia St.
(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME Estella May "White" McCullough

3.(b) Social Security Number None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F	W	Widowed

6.(b) Name of husband or wife: Alexander McCullough

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): August 17, 1884

8. AGE: Years	Months	Days	If less than one day
60	4	25	hrs. min.

9. Birthplace: Cumberland Allegany, Md.
(Town, county, and state)

10. Usual occupation: Housewife

11. Industry or business: Own home

FATHER
12. Name: James H. White
13. Birthplace: Pennsylvania

MOTHER
14. Maiden name: Caroline Elbin
15. Birthplace: Pennsylvania

16. Informant: William E. McCullough
Address: 810 Maplewood Lane

17. Burial
(Burial, cremation, or removal. Which?) Date thereof: Jan 15, 1945
(month) (day) (year)

Cemetery or crematory: Hillcrest Cemetery

Location: Cumberland, Maryland.

18. Funeral director: John J. Hofer
Address: Cumberland, Maryland.

19. Jan 16, 45 Walter R. Beatty, M.D.
(Date rec'd by registrar) Registrar

Jacobson

MEDICAL CERTIFICATION

20. DATE OF DEATH: January 12, 1945, at 7:30 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan 2, 1945, to Jan 12, 1945, and that I last saw her alive on Jan 12, 1945.

Immediate cause of death	DURATION
Cerebral Hemorrhage	10 days.
Due to: Hypertension	
Due to: Arteriosclerosis ?	
Due to: Anemia	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: Harold Jones M.D.
M. D. or other

Address: 15 Liberty St. Date signed: 1/15/45

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (31-C)

CERTIFICATE OF DEATH

00055

Reg. Diat. No. 7

1. PLACE OF DEATH:

County: Allegany

City or town: Nikep

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 30 years

Hospital, Institution, or street address where death occurred: —

How long in hospital or institution? —

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Allegany

City or town: Nikep

(If outside city or town limits, write RURAL and give nearest town)

Street No. —

(If rural, give LOCATION)

2.(a) If veteran, name war —

3. (a) FULL NAME: Catherine Marie McKenzie

3. (b) Social Security Number: —

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Married

6.(b) Name of husband or wife: Laurence McKenzie

6.(c) If alive, give age: 62 years

7. Birth date of deceased (mo., day, yr.): Mar. 23, 1888

8. AGE:

Years	Months	Days	If less than one day
56	10	1	... hrs. ... min.

9. Birthplace: Nikep, Allegany, Maryland (Town, county, and state)

10. Usual occupation: Housework

11. Industry or business: Own home

FATHER

12. Name: Daniel Nolan

13. Birthplace: Virginia

MOTHER

14. Maiden name: Catherine Naughton

15. Birthplace: Ireland

16. Informant: Laurence McKenzie

Address: Nikep, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Jan 27 1945 (month) (day) (year)

Cemetery or crematory: St. Gabriels Cemetery

Location: Barton, Md.

18. Funeral director: My Eichhorn

Address: Lonaconing, Md.

19. Jan 26 1945 (Date rec'd by registrar) D. A. Bowman Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Jan. 24th 1945, at 10:40 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan 23 1945, to Jan 24 1945

and that I last saw her alive on Jan 24 1945

Immediate cause of death	DURATION
cerebral Hemorrhage	
Due to	
Due to	
Other conditions: Chronic Nephritis	

(Include pregnancy within 3 months of death)

Major findings of operations: —

Date of op. —

Autopsy results: —

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide — Date of —

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) —

Means of injury — Injured at work?

23. SIGNATURE: Henry M. Hodgson M.D.

M. D. or other

Address: Lonaconing, Md. Date signed: Jan 25 '45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 93-D

00056

CERTIFICATE OF DEATH

Reg. Diat. No. 9

1. PLACE OF DEATH:
County: Allegany
City or town: Frostburg
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 4 weeks
Hospital, Institution, or street address where death occurred: 164 E Main Street
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Allegany
City or town: Lonaconing - Near Midland
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME: Eleanor McKenzie

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Married

6.(b) Name of husband or wife: Law McKenzie
6.(c) If alive, give age: 79 years

7. Birth date of deceased (mo., day, yr.): Nov. 22, 1866

8. AGE: Years 78 | Months 1 | Days 28 | If less than one day: hrs. min.

9. Birthplace: Rawlings, Allegany Co., Md. (Town, county, and state)
10. Usual occupation: Housework
11. Industry or business: None
FATHER 12. Name: John Thrasher
FATHER 13. Birthplace: Unknown
MOTHER 14. Maiden name: Robinson
MOTHER 15. Birthplace: Unknown
16. Informant: Mrs. Mary Parks
Address: Frostburg, Md.
17. Burial (Burial, cremation, or removal. Which?) Date thereof: Jan. 23 1945 (month) (day) (year)
Cemetery or crematory: Belvedere Cemetery
Location: Midland, Md.
18. Funeral director: M. Eichhorn
Address: Lonaconing, Md.
19. 1-22 1945 Mrs. Nalley D Roe Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Jan 20 19 45, at 10 00 A.M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 19 44, to Jan 20 19 45
and that I last saw her alive on Jan 20 19 45

	DURATION
Immediate cause of death: Coronary Thrombosis	1 day
Due to: Chronic Myocarditis	6 mo
Due to:	
Other conditions: Senility	

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide. Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE: Wm McLane Jr MD M. D. or other
Address: Frostburg Md Date signed 1-20-45

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

Evidence for change of age of deceased is shown on FILM No. G 9 2 MAR 10 1945

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (6)

CERTIFICATE OF DEATH

00057

Reg. Diat. No. 4

1. PLACE OF DEATH:

County: Allegany

City or town: Cumberland, Maryland

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, Institution, or street address where death occurred: Allegany Hospital

How long in hospital or institution? 8 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: W. Va. County: Morgan

City or town: near Berkeley Springs

(If outside city or town limits, write RURAL and give nearest town)

Street No.: Stotler Cross Roads

(If rural, give LOCATION)

2.(a) If veteran, name war: ✓

3. (a) FULL NAME: Emma E. Merchant

3. (b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
female	White	Married

6.(b) Name of husband or wife: Edward Merchant

6.(c) If alive, give age: ..... years

7. Birth date of deceased (mo., day, yr.): Jan 3, 1879

8. AGE: Years	Months	Days	If less than one day
65 ~~66~~	0	8	..... hrs. ..... min.

9. Birthplace: West Virginia (Town, county, and state)

10. Usual occupation: Housewife

11. Industry or business:

FATHER — 12. Name: Thomas Myers

13. Birthplace: W. Va.

MOTHER — 14. Maiden name: Sarah Norcutt

15. Birthplace: W. Va.

16. Informant: Edward Merchant

Address: Stotler Cross Roads W. Va.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Jan 14 1945 (month) (day) (year)

Cemetery or crematory: Highland Cemetery

Location: Highland West Va.

18. Funeral director: Hunter Funeral Home

Address: Berkley Springs West Va.

19. Jan. 11 1945 (Date rec'd by registrar) Walter R. Frantz, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 1 — 11 1945 at 6:30 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 1-3 1945 to 1-11 1945 and that I last saw h.. alive on 1-10 1945

Immediate cause of death	DURATION
Myocardeta with Decompensation	8 days
Due to Acute Pyo-Nephritis	8 days
Due to Pulmonary Embolism	2 hrs
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....

Autopsy results: .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE: J. Z. Johnson M.D. M. D. or other

Address: Cumberland, Md. Date signed: 1-11-45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (51-B)

00058

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH:

County: Allegany

City or town: Cumberland (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred: 347 Williams St.

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)

State: Maryland County: Allegany

City or town: Cumb erland (If outside city or town limits, write RURAL and give nearest town)

Street No.: 347 Williams St. (If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME: Archibald Brown Miller

3.(b) Social Security Number: 705-07-6626

4. Sex: Male

5. Color or race: White

6.(a) Single, married, widowed, or divorced: Married

6.(b) Name of husband or wife: Elizabeth Nisbet Miller

6.(c) If alive, give age: 73 years

7. Birth date of deceased (mo., day, yr.): Dec. 11, 1871

8. AGE:	Years	Months	Days	If less than one day
	73	0	28	....hrs. ....min.

9. Birthplace: Galashiels Scotland (Town, county, and state)

10. Usual occupation: Retired Engineer

11. Industry or business: R.R.

FATHER

12. Name: Robert Miller

13. Birthplace: Scotland

MOTHER

14. Maiden name: Isabellea Wilson

15. Birthplace: Scotland

16. Informant: Mrs. Elizabeth Miller

Address: 347 Williams St. Cumberland, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Jan. 12, 1945 (month) (day) (year)

Cemetery or crematory: HillCrest Burial Park

Location: Cumberland, Md.

18. Funeral director: Charles L. George

Address: Cumberland, Md.

19. Jan. 12, 1945 (Date rec'd by registrar) Winter R. Frantz, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Jan. 9, 1945, at 1:30 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from March 13, 1943, to January 9, 1945

and that I last saw him alive on January 7, 1945

	DURATION
Immediate cause of death: cancer of the prostate	5 years
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: cancer of the prostate

Date of op. 1939 ?

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ..... Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury ..... Injured at work?

23. SIGNATURE: [illegible] M.D. or other

Address: Lonaconing, Md. Date signed: 1-11-45

Outside of City Limits

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (170-C)

00059

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH:

County Allegany

City or town Rural near Cumberland

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution or street address where death occurred: Route 3 Cumberland, Md.

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md. County Allegany

City or town Route 3 Cumberland Md.

(If outside city or town limits, write RURAL and give nearest town)

Street No. Bedford Road.

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME Carolyn Joanne Miltenberger

3. (b) Social Security Number None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Single

6.(b) Name of husband or wife

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) July 3 1938

8. AGE: Years	Months	Days	If less than one day
6	6	3	..... hrs. ..... min.

9. Birthplace Cumberland Allegany Co., Md. (Town, county and state)

10. Usual occupation Child.

11. Industry or business

FATHER 12. Name G. Bernard Miltenberger

13. Birthplace Ridgeley W. Va.

MOTHER 14. Maiden name Ethel Clarke

15. Birthplace Dunbar Pa.

16. Informant G. Bernard Miltenberger

Address Route 3 Cumberland Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Jan 9, 1945 (month) (day) (year)

Cemetery or crematory St Peters R.C. Cemetery

Location Cumberland Md.

18. Funeral director John J. Hafer.

Address Cumberland Md.

19 Jan. 8, 1945 (Date rec'd by registrar) Walter R. Trautz M.D. Registrar

MEDICAL CERTIFICATION about

20. DATE OF DEATH January 6th., 1945 at 4.45 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ..... 19..... to ..... 19.....

and that I last saw h..... alive on ..... 19.....

Immediate cause of death	DURATION
(a) Fractured second cervival vertebra	10 minutes.
Due to (b)	
Due to (c)	
Other conditions Fracture right tibia and fibula, lower third.	

(Include pregnancy within 3 months of death)

Major findings of operations ---

Date of op.

Autopsy results no autopsy

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide accident Date of 1-6-45

Where did injury occur? Near Cumberland, Allegany, Md. (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) highway # 220

Means of injury struck by auto Injured at work? no

23. SIGNATURE Prince H. Bowen, M.D. M. D. or other

Address Cumberland, Maryland Date signed 1-7-45

Deputy Medical Examiner - Allegany Co.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 83-6

CERTIFICATE OF DEATH

00060

Reg. Diat. No. 4

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County Allegany

City or town Cumberland

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 5 yrs.

Hospital, Institution, or street address where death occurred 717 Beall St.

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Allegany

City or town Cumberland

(If outside city or town limits, write RURAL and give nearest town)

Street No. 717 Beall St.

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME Amanda Long Duncan

3.(b) Social Security Number None.

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Widowed

6.(b) Name of husband or wife George Duncan

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) July 10 1856

8. AGE: Years	Months	Days	If less than one day
88	6	21	..... hrs. ..... min.

9. Birthplace Va.

(Town, county, and state)

10. Usual occupation Housewife

11. Industry or business

FATHER 12. Name John Long

13. Birthplace Virginia

MOTHER 14. Maiden name Sarah Stafford

15. Birthplace Virginia

16. Informant Mrs Grace Stein.

Address Cumberland.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Feb 3 45 (month) (day) (year)

Cemetery or crematory Rose Hill Cem.

Location Cumberland Md.

18. Funeral director Louis Stein & Sons

Address Cumberland.

19. Feb. 3, 19 45 Winter R. Frantz M.D. Registrar

(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH January 31 1945 at 4:30 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan. 28 1945 to Jan 31 1945

and that I last saw h[illegible] alive on Jan 31 1945

	DURATION
Immediate cause of death Cerebral Thrombosis	3 days
Due to Arteriosclerosis	10 yrs
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operation ..... Date of op. .....

Autopsy results .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE H. C. Elcano M.D. M. D. or other

Address 126 Mexico St Cumberland Md Date signed 2/1/45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 93-D

CERTIFICATE OF DEATH

00061

Reg. Dist. No. 9

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County Allegany
City or town Frostburg
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 3 mos.
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Allegany
City or town Frostburg
(If outside city or town limits, write RURAL and give nearest town)
Street No. 26 Taylor Street
(If rural, give LOCATION)
2.(a) If veteran, name war Spanish American War

3.(a) FULL NAME John Morgan

3.(b) Social Security Number

4. Sex: Male
5. Color or race: White
6.(a) Single, married, widowed, or divorced: Widower
6.(b) Name of husband or wife: Jane F. Knapp Morgan
6.(c) If alive, give age ~ years
7. Birth date of deceased (mo., day, yr.): June 6, 1872.

8. AGE: Years 72 | Months 7 | Days 2 | If less than one day ... hrs. ... min.

9. Birthplace: Barton, Allegany Co. Md.
(Town, county, and state)
10. Usual occupation: Coal Miner
11. Industry or business: Brophy Mine
FATHER 12. Name: Thomas Morgan
13. Birthplace: Wales
MOTHER 14. Maiden name: Eliza Lee
15. Birthplace: England
16. Informant: Wm Morgan
Address: Frostburg, Md.
17. Burial (Burial, cremation, or removal. Which?) Date thereof Jan 11 1945 (month) (day) (year)
Cemetery or crematory: Allegany Cemetery
Location: Frostburg, Md.
18. Funeral director: Jos Eichhorn
Address: Lonaconing, Md.
19. Jan. 11 1945 (Date rec'd by registrar) Mrs Nancy V. Roy Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Jan 8 1945, at 6:00 P M

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from 1940 19.. to Jan 8 1945
and that I last saw h.. alive on Jan 8 1945

	DURATION
Immediate cause of death: Chronic myocarditis	Several years
Due to:	
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations: ... Date of op. ...
Autopsy results: ...
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide ... Date of ...
Where did injury occur? ... (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) ...
Means of injury ... Injured at work?

23. SIGNATURE: M.D. or other
Address: Frostburg Md. Date signed 1-9-45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (131-a)

CERTIFICATE OF DEATH

00662

Reg. Dist. No. 9

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County: Allegany
City or town: Frostburg
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 13 days
Hospital, institution, or street address where death occurred: Miners hospital
How long in hospital or institution? 13 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Allegany
City or town: Frostburg
(If outside city or town limits, write RURAL, and give nearest town)
Street No.: Route 1 National
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: Ambrose Morris

3.(b) Social Security Number: none

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Widowed

6.(b) Name of husband or wife: Mary J. Morris
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): February 25, 1862

8. AGE: Years: 82 | Months: 10 | Days: 12 | If less than one day: hrs. min.

9. Birthplace: Cresaptown / Allegany Cty., Md.
(Town, county, and state)

10. Usual occupation: miner

11. Industry or business: Consol. Coal Co.

FATHER
12. Name: James P. Morris
13. Birthplace: Virginia

MOTHER
14. Maiden name: Rhoda McKenzie
15. Birthplace: Cresaptown Md.

16. Informant: Sarah Morris
Address: Route 1. Frostburg Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Jan. 16, 1945 (month) (day) (year)
Cemetery or crematory: St. Joseph's Cemetery
Location: Midland Md.

18. Funeral director: J. Durst
Address: Frostburg Md.

19. Jan. 9 1945 Mrs. Nancy N. Rice
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Jan 8 1945, at 6 00 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Dec 26 1944, to Jan 8 1945
and that I last saw h... alive on Jan 7 1945

	DURATION
Immediate cause of death: Chronic Nephritis	several years
Due to: Benign Hypertrophy of Prostate	"
Due to: Arteriosclerosis	"
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?):
Means of injury: Injured at work?

23. SIGNATURE: W. M. McLane Jr. M.D.
M. D. or other
Address: Frostburg Md. Date signed: Jan 9 1945

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 18

00063

CERTIFICATE OF DEATH

Reg. Dist. No. 9

1. PLACE OF DEATH:

County: Allegany

City or town: Frostburg

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 3 Years

Hospital, Institution, or street address where death occurred: 35. Broadway

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Allegany

City or town: Frostburg

(If outside city or town limits, write RURAL and give nearest town)

Street No. 35. Broadway

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME: Naomi Catherine Myers

3. (b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Single

6.(b) Name of husband or wife

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): September 17 1915

8. AGE:

Years	Months	Days	If less than one day
29	4	6	..... hrs. ..... min.

9. Birthplace: Ridgeley, Mineral Co, West Virginia (Town, county, and state)

10. Usual occupation: House Duty

11. Industry or business: Own House

FATHER 12. Name: William B. Myers

FATHER 13. Birthplace: Martinsburg, W. Va.

MOTHER 14. Maiden name: Leota Pettie

MOTHER 15. Birthplace: Piedmont, W. Va.

16. Informant: William B. Myers

Address: 35. Broadway, Frostburg, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 1/26/45 (month) (day) (year)

Cemetery or crematory: Rose Hill Cemetery

Location: Cumberland, Md.

18. Funeral director: William H. Kight

Address: Cumberland, Md.

19. 1-25 1945 Mrs. Harvey N. Rose Registrar

(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH: January 23 1945, at 9:30 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from January 22 1945, to Jan 23 1945

and that I last saw h.. alive on January 22 1945

Immediate cause of death	DURATION
Pulmonary Tuberculosis	2 yrs
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE: Hilda Jourdelaltrs, M.D. M. D. or other

Address: Frostburg, Md Date signed 1/25/45

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

Evidence for adding of age of deceased is shown on

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (93-1)

CERTIFICATE OF DEATH

Evidence for change of cause of death is shown on

FILM No. G 94 APR 7 1945 Reg. Dist. No. 4

FILM G 93 MAR 20 1945

00064

1. PLACE OF DEATH:

County Allegany

City or town Cumberland (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, Institution, or street address where death occurred: 152 Wineow St.

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)

State Md. County Allegany

City or town Cumberland (If outside city or town limits, write RURAL and give nearest town)

Street No. 152 Wineow St. (If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME Alice Nash

3.(b) Social Security Number None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	Black	Single

6.(b) Name of husband or wife

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) Unknown

8. AGE: Years	Months	Days	If less than one day
70 to 80			..... hrs. ..... min.

9. Birthplace Martinsburg W. Va. (Town, county, and state)

10. Usual occupation General House Work

11. Industry or business Private Homes

FATHER 12. Name Unknown

13. Birthplace "

MOTHER 14. Maiden name "

15. Birthplace "

16. Informant Susan Smith

Address 152 Wineow St Cumb. Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Jan 16, 1944 (month) (day) (year)

Cemetery or crematory Woodlawn Cemetery

Location Cumberland Md

18. Funeral director John J. Hafer

Address Cumberland Md.

19. Jan 15 1945 (Date rec'd by registrar) Wister P. Trautz, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH January 17, 1945, at 9:30 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ..... 19..... to ..... 19.....

and that I last saw h..... alive on ..... 19.....

Immediate cause of death	DURATION
Myocarditis	
Due to Duration 5 years	
Due to	
Due to	
Other conditions Old age	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Geo P Faulkner M. D. or other

Address Cumb Md Date signed

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (83a)

00065

CERTIFICATE OF DEATH

Reg. Dist. No. 4

M

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

1. PLACE OF DEATH:
County Allegany
City or town Cumberland (If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 15 yrs.
Hospital, institution, or street address where death occurred: 32 Laing Ave
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)
State Md County Allegany
City or town Cumberland (If outside city or town limits, write RURAL and give nearest town)
Street No. 32 Laing Ave. (If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME Annie Isadora Nazelrod
3.(b) Social Security Number None

4. Sex Female
5. Color or race White
6.(a) Single, married, widowed, or divorced Married
6.(b) Name of husband or wife Jonah P. Nazelrod
6.(c) If alive, give age ... years
7. Birth date of deceased (mo., day, yr.) Jan 26, 1886

8. AGE:	Years	Months	Days	If less than one day
	58	11	25	... hrs. ... min.

9. Birthplace Mathias, Hardy Co., W. Va (Town, county, and state)
10. Usual occupation Housework
11. Industry or business At Home
FATHER 12. Name Reuben Nazelrod.
13. Birthplace Orkney Springs Va.
MOTHER 14. Maiden name Eliza Snyder
15. Birthplace Orkney Springs Va.
16. Informant Edgar Nazelrod
Address 10 Hampton Place - Cumb.
17. Burial (Burial, cremation, or removal. Which?) Date thereof Jan 24, 1945 (month) (day) (year)
Cemetery or crematory Hillcrest Cemetery
Location Cumberland, Md.
18. Funeral director John J. Hafer
Address Cumberland Md
19. Jan 24, 1945 (Date rec'd by registrar) Winter R. Ovanty, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH January 21, 1945, at 6:50 P.M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan 20, 1945, to Jan 21, 1945, and that I last saw her alive on Jan 21, 1945

Immediate cause of death	DURATION
Cerebral apoplexy	22h
Due to Arterio sclerosis	4 yrs
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE M. E. B. Owens M. D. or other
Address 133 [illegible] Date signed 1/22/45

M. E. B. Owens

DR. L. BRINGS

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 44a

00066

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH:
County: Allegany
City or town: Cumberland, Maryland
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, Institution, or street address where death occurred:
Memorial Hospital
How long in hospital or institution? 7 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Allegany
City or town: Cresaptown
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME: Mrs. Genevieve Nicholson

3.(b) Social Security Number: 214-07-3606

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Married

6.(b) Name of husband or wife: Edward Nicholson
6.(c) If alive, give age: 27 years

7. Birth date of deceased (mo., day, yr.): May 4 1916

8. AGE: Years	Months	Days	If less than one day: hrs.	min.
28	8	7		

9. Birthplace: Blaine W. Va.
(Town, county, and state)
10. Usual occupation: Celanese Employee
11. Industry or business
FATHER 12. Name: James B. Stewart
13. Birthplace: W. Va.
MOTHER 14. Maiden name: Flossie Walters
15. Birthplace: Maryland
16. Informant: Memorial Hospital
Address: Cumberland, Maryland
17. Burial (Burial, cremation, or removal. Which?) Date thereof Jan 15 '45 (month) (day) (year)
Cemetery or crematory: Hillcrest Cem.
Location: Cumberland
18. Funeral director: Louis Stein Inc
Address: Cumberland
19. Jan. 13 1945 (Date rec'd by registrar) Walter R. Bantz, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: January 11, 1945 1945 at 9:00P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from November 2 1944 to January 11 1945 and that I last saw h.. alive on January 11 1945

Immediate cause of death: cause of the army — DURATION: for months
Due to:
Due to:
Other conditions:
(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: L Brings MD
M. D. or other
Address: Long Mdw Date signed 1-12-45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A16

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (46d)

CERTIFICATE OF DEATH

00667

Reg. Diat. No. 4

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County Allegany

City or town Cumberland Md

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 49 yrs

Hospital, institution, or street address where death occurred: Allegany Hospital Cumberland Md

How long in hospital or institution? 21 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Allegany

City or town 440 Baltimore St

(If outside city or town limits, write RURAL and give nearest town)

Street No. Cumberland Md

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME Mrs. Mrs. Ethel

3. (b) Social Security Number 217-18-4995

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Widowed

6.(b) Name of husband or wife George Rice

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) Feb. 26th, 1895

8. AGE: Years	Months	Days	If less than one day
49	10	27	..... hrs. ..... min.

9. Birthplace Cumberland Maryland (Town, county, and State)

10. Usual occupation Presser

11. Industry or business Crystal Laundry

FATHER 12. Name James B Nigger Snd

13. Birthplace

MOTHER 14. Maiden name Daisy Rose Shanks

15. Birthplace

16. Informant James B Nigger

Address Cumberland

17. Burial (Burial, cremation, or removal. Which?) Date thereof Jan 25 45 (month) (day) (year)

Cemetery or crematory St P & P Cem

Location Cumberland

18. Funeral director Lomo Stein Inc

Address Cumberland

19. Jan 24 19 45 (Date rec'd by registrar) Walter R. Beauty, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan 22 19 45 at 4:45 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan 5 19 45, to Jan 22 19 45 and that I last saw h-r alive on Jan 22 19 45

Immediate cause of death Carcinoma of Rectum

DURATION

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations Exploratory Laparotomy Mass at Sigmoid & rectum Date of op. 1/18/45

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE J Bailey Hunter M.D. M. D. or other

Address Cumberland Md Date signed 1/24/45

DR. ELIASON

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (15-2)

CERTIFICATE OF DEATH

00068

Reg. Dist. No. 4

1. PLACE OF DEATH:
County ALLEGANY
City or town CUMBERLAND, MD.
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred: MEMORIAL HOSPITAL
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State WEST VIRGINIA County TUCKER
City or town THOMAS
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If roral, give LOCATION)
2.(a) If veteran, name war ✓

3. (a) FULL NAME MARY YVONNE NUTTER

3. (b) Social Security Number None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
FEMALE	WHITE	SINGLE

6.(b) Name of husband or wife
8.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) DECEMBER 29, 1943

8. AGE: Years	Months	Days	If less than one day
1	0	15	hrs. min.

9. Birthplace VIRGINIA (Town, county, and state)
10. Usual occupation
11. Industry or business

FATHER
12. Name HARRY A. NUTTER
13. Birthplace MARYLAND

MOTHER
14. Maiden name CARMELIA DILETOSSA
15. Birthplace WEST VIRGINIA

16. Informant MRS. HARRY NUTTER
Address THOMAS W.VA.

17. Burial Removal (Burial, cremation, or removal. Which?) Date thereof Jan 16 1945 (month) (day) (year)
Cemetery or crematory St. THOMAS
Location THOMAS, W. VA.

18. Funeral director J. D. Duncan
Address Thomas W. Va.

19. Jan. 15, 1945 (Date rec'd by registrar) Walter R. Frantz, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH JANUARY 13, 1945 at 2:45 A.M.

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from 1-12-45 to 1-13-45 and that I last saw h... alive on 1-13-45

Immediate cause of death	DURATION
Patent Foramen Vale	1 Yr.
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE H. C. Leonard M. D. or other
Address 106 Harrison Cumberland Md Date signed 1/13/45

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

Outside of City limits

00069

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (93-D)

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH:
County: Allegany
City or town: Cumberland (Rural)
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 30 yrs.
Hospital, Institution, or street address where death occurred: Willow Brook Rd.
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Allegany
City or town: Cumberland (Rural)
(If outside city or town limits, write RURAL and give nearest town)
Street No. Willow Brook Rd.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME Christina P. Pfeffer

3.(b) Social Security Number None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Single

6.(b) Name of husband or wife

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) May 15 1866

8. AGE:

Years	Months	Days	If less than one day
78	7	27	..... hrs. ..... min.

9. Birthplace: Bedford Co., Pa.
(Town, county, and state)

10. Usual occupation: Housework

11. Industry or business: At Home

FATHER
12. Name: John C. Pfeiffer
13. Birthplace: Germany

MOTHER
14. Maiden name: Elizabeth Wahl
15. Birthplace: Germany

16. Informant: Wm. A. Pfeiffer
Address: Willow Brook Rd.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Jan 14 45 (month) (day) (year)
Cemetery or crematory: Hillcrest Cem.
Location: Cumberland

18. Funeral director: Louis Stein & Son
Address: Cumberland

19. Jan. 13 1945 (Date rec'd by registrar) Walter L. Trauth, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Jan 12 1945, at 9 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan. 11 1945, to Jan. 12 1945, and that I last saw h. alive on Jan. 11, 1945.

	DURATION
Immediate cause of death: Chronic Myocarditis	
Due to: Not determined	
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: Charlotte B. Gardner M. D. or other
Address: Cumberland, Md. Date signed 1-13-45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 160-C

00070

CERTIFICATE OF DEATH

Reg. Dist. No. 9

1. PLACE OF DEATH:

County: Allegany

City or town: Frostburg

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, Institution, or street address where death occurred: Miners Hospital

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Allegany

City or town: Frostburg

(If outside city or town limits, write RURAL and give nearest town)

Street No.: 121 McCulloh St.

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME Baby Boy Phillips

3.(b) Social Security Number none

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Single

6.(b) Name of husband or wife

6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.): January 28, 1945

8. AGE: Years | Months | Days | If less than one day: 6 hrs. min.

9. Birthplace: Frostburg Allegany Cty, Md. (Town, county, and state)

10. Usual occupation

11. Industry or business

FATHER 12. Name: Meril A. Phillips

13. Birthplace: Pennsylvania

MOTHER 14. Maiden name: Margaret E. Walker

15. Birthplace: Maryland

16. Informant: Meril A. Phillips

Address: Frostburg, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Jan. 29 '45 (month) (day) (year)

Cemetery or crematory: Allegany Cemetery

Location: Frostburg Md.

18. Funeral director: J. J. Durst

Address: Frostburg Md.

19. 1-29 1945 Mrs. Hainey L. Roe

(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: January 28 1945, at 8:35 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from January 28 1945, to Jan 28 1945

and that I last saw him alive on January 28 1945

Immediate cause of death	DURATION
Prematurity	
Due to Placenta Previa & Hemorrhage	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE: Hilda Lauer Walker, M.D.

M. D. or other

Address: Frostburg, Md. Date signed 1/28/45

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (94a)

00671

CERTIFICATE OF DEATH

Reg. Dist. No. 1

1. PLACE OF DEATH:

County Allegany

City or town R.F.D. 1 Hancock Md.
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 15 yrs.

Hospital, Institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants, give residence of mother)

State Maryland County Allegany

City or town R.F.D. 1 Hancock Md.
(If outside city or town limits, write RURAL and give nearest town)

Street No.
(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME Ellen Potter

3.(b) Social Security Number

4. Sex: Female | 5. Color or race: White | 6.(a) Single, married, widowed, or divorced: Widowed

6.(b) Name of husband or wife: Deceased

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): OCT 17 1865

8. AGE: Years 79 | Months 2 | Days 29 | If less than one day ..... hrs. ..... min.

9. Birthplace Philadelphia Pa.
(Town, county and state)

10. Usual occupation Retired

11. Industry or business

FATHER
12. Name James Wilson
13. Birthplace Ireland

MOTHER
14. Maiden name Agnes Kay
15. Birthplace Scotland

16. Informant Daniel F. Morris
Address Hancock Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Jan 14 1945 (month) (day) (year)

Cemetery or crematory Presbyterian

Location Hancock Md.

18. Funeral director J. D. Lewis Sons

Address Hancock Md.

19. Jan 12. 1945 T. T. Mann per M E Mann
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan. 11, 1945 at 7 A. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan. 8 1945 to Jan. 11 1945 and that I last saw her alive on Jan. 10, 1945

Immediate cause of death	DURATION
Acquired pedis	2 days
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations ..... Date of op. .....

Autopsy results .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ..... Date of .....

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury ..... Injured at work?

23. SIGNATURE J. A. Watson M.D
M. D. or other

Address Little Orleans Md. Date signed 1/12/45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

00072

Reg. Dist. No. .....

[redacted]

1. PLACE OF DEATH:

County Allegany

City or town Luke
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 48 yrs 2 yrs

Hospital, Institution, or street address where death occurred:
Pratt St.

How long in hospital or Institution? .....

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Md. County Allegany

City or town Luke
(If outside city or town limits, write RURAL and give nearest town)

Street No. Pratt St.
(If rural, give LOCATION)

2.(a) If veteran, name war .....

3.(a) FULL NAME Ida Belle Richards

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Married

6.(b) Name of husband or wife James J. Richards

6.(c) If alive, give age 72 years

7. Birth date of deceased (mo., day, yr.) Jan. 16, 1873

8. AGE: Years 72 | Months | Days 6 | If less than one day ..... hrs. ..... min.

9. Birthplace Cochranville, Chester, Pa.
(Town, county, and state)

10. Usual occupation Housewife

11. Industry or business Own home

FATHER 12. Name George Cochran

13. Birthplace Cochranville, Pa.

MOTHER 14. Maiden name Elizabeth Cunningham

15. Birthplace New Castle, Delaware

16. Informant Mrs. James J. Richards

Address Pratt St. Luke, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Jan. 26, 1945 (month) (day) (year)

Cemetery or crematory Shiloh

Location Westernport, Md.

18. Funeral director Mrs. Ray Boal Berry

Address Westernport, Md.

19 Jan. 26 1945 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan. 23, 1945, at 2:25 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan 14 1945 to Jan 23 1945 and that I last saw h[illegible] alive on Jan 23 1945

Immediate cause of death	DURATION
Myocarditis	1 yr
Due to Myocardial degeneration	2 yrs
Due to	
Other conditions Uterine fibroma	5 yrs

(Include pregnancy within 3 months of death)

Major findings of operations .....

Date of op. .....

Autopsy results .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE [redacted] M. D. or other

Address [redacted] Date signed 1/25/45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (21)

00073

CERTIFICATE OF DEATH

Reg. Dist. No. 9

1. PLACE OF DEATH:

County: Allegany

City or town: Borden Shaft
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, Institution, or street address where death occurred: Borden Shaft

How long in hospital or Institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Md County: Allegany

City or town: Borden Shaft
(If outside city or town limits, write RURAL and give nearest town)

Street No. R.F.D. #1, Box 42
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME Robert Guy Ritchie

3. (b) Social Security Number none

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	W	married

6.(b) Name of husband or wife: Emma Ritchie

6.(c) If alive, give age: 59 years

7. Birth date of deceased (mo., day, yr.): May 25 1884

8. AGE:

Years	Months	Days	If less than one day
60	8	4	..... hrs. ..... min.

9. Birthplace: Frostburg, Allegany, Maryland
(Town, county, and state)

10. Usual occupation: Salesman

11. Industry or business: Fuller Brush Co.

FATHER
12. Name: James Ritchie Sr.
13. Birthplace: England

MOTHER
14. Maiden name: Sarah Tilbury
15. Birthplace: England

16. Informant: Carl Ritchie
Address: Frostburg, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Jan 28-1945 (month) (day) (year)

Cemetery or ~~crematory~~: Allegany

Location: Frostburg

18. Funeral director: J. J. Dunkle

Address: Frostburg

19. Jan-26 1945 (Date rec'd by registrar) Mrs. Vaudy N. Roe Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH January 25 1945, at 11:50 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 1-23 1945, to 1-25 1945

and that I last saw h. I'M alive on 1-25 1945

Immediate cause of death	DURATION
Coronary occlusion	48 hrs.
Due to	
Due to	
Other conditions	
(Include pregnancy within 3 months of death)	

Major findings of operations: Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: H. C. Diehl, M.D.
M. D. or other

Address: Frostburg, Md. Date signed: 1-26-45

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (937)

00074

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH:
County: Allegany
City or town: Cumberland
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? ✓
Hospital, institution, or street address where death occurred: Memorial Hospital
How long in hospital or institution? 2 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: W. Va. County: Berkeley
City or town: Paw Paw
(If outside city or town limits, write RURAL and give nearest town)
Street No. ✓
(If rural, give LOCATION)
2.(a) If veteran, name war ✓

3. (a) FULL NAME: Lillie M. Robertson

3. (b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F	W.	Married

6.(b) Name of husband or wife: James M. Robertson
6.(c) If alive, give age: 72 years

7. Birth date of deceased (mo., day, yr.): June 6 1878

8. AGE: Years	Months	Days	If less than one day
66	7	19	...hrs. ...min.

9. Birthplace: Maryland (Town, county, and state)
10. Usual occupation: Housewife
11. Industry or business: —

FATHER
12. Name: (Buck) Dean
13. Birthplace: Md.

MOTHER
14. Maiden name: Matilda Middleton
15. Birthplace: Md.

16. Informant: James Robertson
Address: Paw Paw. W.Va.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Jan 28 1945 (month) (day) (year)
Cemetery or crematory: Camp Hill
Location: Paw Paw. W.Va.

18. Funeral director: Louis Stein, Inc.
Address: Cumberland, Md.

19. Jan 27 1945 (Date rec'd by registrar) Walter R. Frantz M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: January 25 1945, at 12:35 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan. 23 1945, to Jan 25 1945 and that I last saw h...er alive on Jan 25 1945

Immediate cause of death	DURATION
Internal Embolism (Common Iliac)	3 weeks
Due to: Auricular Fibrillation	3 years
Due to: Myocardial Disease	3 yrs
Other conditions: Uremia and decompensating	

(Include pregnancy within 3 months of death)

Major findings of operations: ...Date of op. ...
Autopsy results: Gave consent -
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: ... Date of ...
Where did injury occur? ... (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) ...
Means of injury ... Injured at work?

23. SIGNATURE: Russell Jacobs M.D. M. D. or other
Address: 15 E. Liberty St. Date signed: 1/25/45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (94 01)

CERTIFICATE OF DEATH

00075

Reg. Diat. No. 4

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County: Allegany
City or town: Cumberland
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred:
618 Va. Ave.
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Allegany
City or town: Rural Cumberland
(If outside city or town limits, write RURAL and give nearest town)
Street No.: R.D.#4
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME: Clarence Hedges Schad

3. (b) Social Security Number: >

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: Anna Schad
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): Apr. 28, 1886

8. AGE: Years	Months	Days	If less than one day
58	8	11	..... hrs. ..... min.

8. Birthplace: Martinsburg, W. Va.
(Town, county, and state)
10. Usual occupation: Pipe Fitter >
11. Industry or business

FATHER
12. Name: John Schad
13. Birthplace: Germany

MOTHER
14. Maiden name: Ella Jackson
15. Birthplace: Germany

16. Informant: Mrs. Anna Schad
Address: 6 W. First St. Cumberland, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Jan. 11 1945 (month) (day) (year)
Cemetery or crematory: St. Mary's Cemetery
Location: Cumberland, Md.

18. Funeral director: Charles L. George
Address: Cumberland, Md.

19. Jan. 10 1945 (Date rec'd by registrar) Winter R. Frantz, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: January 8th., 1945, at about 11:30 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ..... 19..... to ..... 19.....
and that I last saw h..... alive on ..... 19.....

Immediate cause of death	DURATION
Coronary Occlusion	
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ---
Date of op.
Autopsy results: no autopsy
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide ..... Date of .....
Where did injury occur? ..... (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) .....
Means of injury ..... Injured at work?

23. SIGNATURE: Prince H. Dotson M.D.
M. D. or other
Address: Cumberland, Maryland Date signed: 1-9-45

Deputy Medical Examiner - Allegany Co.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (163-H)

00076

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH

County: Allegany

City or town: Cumberland

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 6 mo.

Hospital, Institution, or street address where death occurred: 222 Arch st.

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Allegany

City or town: Cumberland

(If outside city or town limits, write RURAL and give nearest town)

Street No. 222 Arch st

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME Helen Schaver

3.(b) Social Security Number None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F	W	Married

8.(b) Name of husband or wife: Walter Henry

8.(c) If alive, give age: ..... years

7. Birth date of deceased (mo., day, yr.): June 7, 1912

8. AGE: Years	Months	Days	If less than one day
32	7	20	..... hrs. ..... min.

9. Birthplace: Chagrin Falls, Ohio (Town, county, and state)

10. Usual occupation: Housewife

11. Industry or business

FATHER 12. Name: Norman W. Rood

13. Birthplace: Ohio

MOTHER 14. Maiden name: Gertrude Lafferty

15. Birthplace: Ohio

16. Informant: Walter H. Schaver

Address: Cumberland Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 1/30/45 (month) (day) (year)

Cemetery or crematory: Chagrin Falls Cem

Location: Chagrin Falls Ohio

18. Funeral director: Louis Stein Inc.

Address: Cumberland Md.

19. Jan. 28 1945 (Date rec'd by registrar) Winter R. Frantz, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: about January 27th., 1945, at 1 A: M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ..... 19..... to ..... 19.....

and that I last saw h..... alive on ..... 19.....

Immediate cause of death	DURATION
Suicide by Asphyxiation (illuminating gas)	
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ---

Date of op.

Autopsy results: no autopsy

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: suicide Date of 1-27-45

Where did injury occur? Cumberland, Allegany, Md. (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) home

Means of injury illuminating gas Injured at work? no

23. SIGNATURE: Prince H. Watson, M.D. M. D. or other

Address: Cumberland, Maryland Date signed 1-27-45

Deputy Medical Examiner - Allegany Co.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (18)

00077

CERTIFICATE OF DEATH

Reg. Diat. No. 4

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County: Allegany

City or town: Cumberland

(If outside city or towo limits, write RURAL and give nearest town)

How tong in above place of death? 6 mo.

Hospital, Institution, or street address where death occurred: 222 arch st

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: allegany

City or town: Cumberland

(If outside city or town limits, write RURAL and give nearest town)

Street No. 222 Arch st

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME: Sondra Schaver

3.(b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Single

6.(b) Name of husband or wife

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): Sept. 13, 1937

8. AGE:

Years	Months	Days	If less than one day
7	4	14	..... hrs. ..... min.

8. Birthplace: Columbus Ohio (town, county, and state)

10. Usual occupation: Student

11. Industry or business

FATHER — 12. Name: Walter Henry Schaver

13. Birthplace: W. Va.

MOTHER — 14. Maiden name: Helen L Reed

15. Birthplace: Ohio

16. Informant: Walter H. Schaver

Address: Cumberland Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 1/30/45 (month) (day) (year)

Cemetery or crematory: Chagrin Falls Cem

Location: Chagrin Falls Ohio

18. Funeral director: Louis Stein Sons

Address: Cumberland Md.

19. Jan. 28, 1945 (Date rec'd by registrar) Winter K. Krantz, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: about January 27th., 1945, at 1 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ..... 19..... to ..... 19.....

and that I last saw h..... alive on ..... 19.....

Immediate cause of death	DURATION
Homicide by Asphyxiation (illuminating gas)	
Due to	
Due to	
Other conditions ---	

(Include pregnancy within 3 months of death)

Major findings of operations: ---

Date of op.

Autopsy results: no autopsy

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: homicide Date of 1-27-45

Where did injury occur? Cumberland, Allegany, Md. (City or town) (County) (State)

Injured at home, farm, industry, public place (where?): home

Means of injury: illuminating gas Injured at work? no

23. SIGNATURE: Clarence H. Lowe M.D. M. D. or other

Address: Cumberland, Maryland Date signed: 1-27-45

Deputy Medical Examiner - Allegany Co.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (83-a)

CERTIFICATE OF DEATH

00078

Reg. Dist. No. 8

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County: Allegany
City or town: Frostburg
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 24 years
Hospital, institution, or street address where death occurred: —
How long in hospital or institution? —

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Allegany
City or town: Frostburg
(If outside city or town limits, write RURAL and give nearest town)
Street No. —
(If rural, give LOCATION)
2.(a) If veteran, name war —

3.(a) FULL NAME: Elizabetta Munsie Schell

3.(b) Social Security Number: —

4. Sex: Female
5. Color or race: White
6.(a) Single, married, widowed, or divorced: Widowed
6.(b) Name of husband or wife: Henry Schell
6.(c) If alive, give age — years
7. Birth date of deceased (mo., day, yr.): July 21, 1860
8. AGE: Years: 84 Months: 5 Days: 22 If less than one day: ... hrs. ... min.
9. Birthplace: Scotland (Town, county, and state)
10. Usual occupation: Housework
11. Industry or business: Own home
12. Name of father: Unknown
13. Birthplace of father: Eckhart
14. Maiden name of mother: Mary
15. Birthplace of mother: Scotland
16. Informant: Mrs. Elizabeth Begley
Address: Frostburg, Md.
17. Burial (Burial, cremation, or removal. Which?) Date thereof Jan. 17, 1945 (month) (day) (year)
Cemetery or crematory: Allegany Cemetery
Location: Frostburg
18. Funeral director: M. Eichhorn
Address: Lonaconing, Md.
19. Jan. 16 1945 (Date rec'd by registrar) W. E. Dan Taylor Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Jan. 13 1945, at 4:45 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan. 10 1945, to Jan. 13 1945 and that I last saw her alive on Jan. 10 1945

Immediate cause of death	DURATION
Cerebral Hemorrhage	
Due to	
Due to	
Other conditions: Pernicious Cerebral Hemorrhage	

(Include pregnancy within 3 months of death)

Major findings of operations: —
Date of op. —
Autopsy results: —
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide — Date of —
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) —
Means of injury — Injured at work?

23. SIGNATURE: Henry M. Hodgson M.D.
M. D. or other
Address: Lonaconing, Md. Date signed: Jan 16 '45

Dr. Eliason

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (109)

CERTIFICATE OF DEATH

00679

Reg. Dist. No. 4

1. PLACE OF DEATH:
County ALLEGANY
City or town CUMBERLAND, MD.
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 15 DAYS
Hospital, Institution, or street address where death occurred:
MEMORIAL HOSPITAL
How long in hospital or institution? 15 DAYS

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State W. VA. County HAMPSHIRE
City or town GREENSPRING
(If outside city or town limits, write RURAL and give nearest town)
Street No. ..... (If rural, give LOCATION)
2.(a) If veteran, name war ✓

3.(a) FULL NAME
ELEANOR SEEDERS

3.(b) Social Security Number
None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
FEMALE	W	SINGLE

6.(b) Name of husband or wife .....
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) September 19, 1929

8. AGE: Years	Months	Days	If less than one day
15	3	17	..... hrs. ..... min.

9. Birthplace West Virginia (Town, county, and state)
10. Usual occupation Student
11. Industry or business

FATHER
12. Name WILLIAM SEEDERS
13. Birthplace WEST VIRGINIA

MOTHER
14. Maiden name BEULAH MESSICK
15. Birthplace WEST VIRGINIA

16. Informant MEMORIAL HOSPITAL
Address CUMBERLAND, MD.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Jan 9 45 (month) (day) (year)
Cemetery or ~~crematory~~ Forrest Glen
Location Greenspring, W. Va
18. Funeral director Thrush's
Address Romney, W. Va.

19. Jan 8, 1945 (Date rec'd by registrar) Walter L. Bantz M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH January 6, 1945 at ..... M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 12-27-44 to 1-6 1945
and that I last saw h... alive on 1-6 1945

	DURATION
Immediate cause of death Lobar Pneumonia	4 D
Due to Diabetes Mellitus	4 D
Due to	
Due to	
Other conditions Venous Influenza	

(Include pregnancy within 3 months of death)

Major findings of operations .....
Date of op. .....
Autopsy results .....
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide ..... Date of .....
Where did injury occur? ..... (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) .....
Means of injury ..... Injured at work?

23. SIGNATURE H. H. Lemon M.D.
M. D. or other
Address 126 Union St Cumberland Date signed 1/6/45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (21)

00080

CERTIFICATE OF DEATH

Reg. Dist. No. 4

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County: Allegany

City or town: Near Cumberland, Rural

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 86 Years

Hospital, Institution, or street address where death occurred: R.F.D. # 1.

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newboro infants give residence of mother)

State: Maryland County: Allegany

City or town: Near Cumberland, Rural

(If outside city or town limits, write RURAL and give nearest town)

Street No. R. F. D. # 1.

(If roral, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME: Henry Shaffer

3.(b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Widowed

6.(b) Name of husband or wife: Annie Shaffer

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): January 9 1859

8. AGE: Years	Months	Days	If less than one day
86	0	6	..... hrs. ..... min.

9. Birthplace: Cumberland, Allegany Co, Maryland

(Town, county, and state)

10. Usual occupation: Labor

11. Industry or business: Union Tannery Co (Retired)

FATHER

12. Name: Conrad Shaffer

13. Birthplace: Germany

MOTHER

14. Maiden name: Sophia Oley

15. Birthplace: Germany

18. Informant: Paul H. Shaffer

Address: R.F.D. # 1, Cumberland, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 1/18/45 (month) (day) (year)

Cemetery or crematory: St Lukes Cemetery

Location: Cumberland, Md.

18. Funeral director: William H. Kight

Address: Cumberland, Md.

19. Jan. 18, 1945 (Date rec'd by registrar) Wm. F. Bantz, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Jan 15 1945; at 6 30 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan 5 1945, to Jan 15 1945

and that I last saw him alive on Dec 28 1944

Immediate cause of death	DURATION
Myocardial Insufficiency	1 yr
Due to: Arteriosclerosis	1 mo
Due to: Senility	2 days
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: F. Clay G. Lewis Med M. D. or other

Address: Cumberland Md. Date signed: Jan 16 1945

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (830)

00081

CERTIFICATE OF DEATH

Reg. Diat. No. 4

1. PLACE OF DEATH:

County: allegany

City or town: Cumberland

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 74 yrs

Hospital, institution, or street address where death occurred:

840 Columbia Ave.

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Md County: allegany

City or town: Cumberland

(If outside city or town limits, write RURAL and give nearest town)

Street No. 840 Columbia Ave.

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME Mrs Catherine Elizabeth "Seaders" Siefers

3. (b) Social Security Number None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Widow

6.(b) Name of husband or wife: Joseph Siefers

6.(c) If alive, give age: ____ years

7. Birth date of deceased (mo., day, yr.): Feb 24, 1860

8. AGE: Years	Months	Days	If less than one day
84	10	23	____ hrs. ____ min.

9. Birthplace: Baltimore Md.
(Town, county, and state)

10. Usual occupation: Housework

11. Industry or business: At Home.

FATHER
12. Name: Joseph Seaders
13. Birthplace: Baltimore, Md.

MOTHER
14. Maiden name: Mary Bach
15. Birthplace: Baltimore Md.

16. Informant: Joseph Siefers
Address 840 Columbia Ave - Cumb Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Jan 20 1944 (month) (day) (year)

Cemetery or crematory: St. Peters + Pauls Cemetery

Location: Cumberland Md

18. Funeral director: John J. Hafer

Address: Cumberland Md

19. Jan. 19, 1945 (Date rec'd by registrar) Witter P. Krantz M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH January 17, 1945, at 8:15 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 12/15/44, 19__, to 1/17/45, 19__

and that I last saw h.er alive on 1/17/45, 19__

Immediate cause of death	DURATION
Cerebral hemorrhage	
Due to: —	
Due to: —	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ____ Date of op. ____

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ____ Date of ____

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: ____ Injured at work?

23. SIGNATURE: John J. Rozzell M.D. (M. D. or other)

Address: Cumberland Md. Date signed 1/19/45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

Dr Wilson

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (21)

00082

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH:
County ALLEGANY
City or town CUMBERLAND, MARYLAND
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 30 years
Hospital, Institution, or street address where death occurred: Memorial Hospital
How long in hospital or institution? FIVE DAYS

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State MARYLAND County ALLEGANY
City or town CUMBERLAND
(If outside city or town limits, write RURAL and give nearest town)
Street No. 509 VALLEY ST.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME PHYLLIS SKIDMORE

3.(b) Social Security Number None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
FEMALE	WHITE	MARRIED

6.(b) Name of husband or wife CHARLES ALBERT SKIDMORE
6.(c) If alive, give age 66 years
7. Birth date of deceased (mo., day, yr.) OCTOBER 6, 1882

8. AGE: Years	Months	Days	If less than one day
62	3	23	hrs. min.

9. Birthplace MARYLAND Frostburg
(Town, county, and state)
10. Usual occupation Housewife
11. Industry or business Own home
FATHER 12. Name JOHN PRESSMAN
13. Birthplace MD.
MOTHER 14. Maiden name MARTHA SNYDER
15. Birthplace MD.
16. Informant Charles Skidmore
Address 509 Valley St
17. Burial (Burial, cremation, or removal. Which?) Date thereof Feb 1 1945 (month) (day) (year)
Cemetery or crematory Rummount Cemetery
Location Cumberland, Md.
18. Funeral director John L. Hafer
Address Cumberland, Md.
19. Jan 30 1945 (Date rec'd by registrar) Walter R. Trautz, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH January 29 1945 at 3:26 P M
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan 24 1945 to Jan 29 1945 and that I last saw her alive on Jan 29 1945

	DURATION
Immediate cause of death: Embolism Pulmonary	
Due to: Gangrene of right leg	7 days
Due to: Arteriosclerosis	
Due to: Diabetes Mellitus	?
Other conditions: Chronic Myocarditis	?

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results Confirmed clinical diagnosis
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE Edward Stone Jr. M. D. or other
Address Cumberland Md. Date signed 1-29-45

M

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

T

Dr. Meyers.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 47

00083

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH:
County ALLEGANY
City or town CUMBERLAND (If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, Institution, or street address where death occurred:
MEMORIAL HOSPITAL
How long in hospital or institution? 9 DAYS

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)
State MARYLAND County ALLEGANY
City or town CUMBERLAND (If outside city or town limits, write RURAL and give nearest town)
Street No. 603 MARYLAND AVE., (If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME SMITH, THOMAS A. MR.

3.(b) Social Security Number 220-10-6505

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
MALE	WHITE	WIDOWER

6.(b) Name of husband or wife BRADBURN, MARGARET
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) August 16, 1866

8. AGE: Years	Months	Days	If less than one day
78	4	7	..... hrs. ..... min.

9. Birthplace MARYLAND Lonaconing, Md (Town, county, and state)
10. Usual occupation Salesman
11. Industry or business Potomac Edison Co.

FATHER
12. Name SMITH, THOMAS
13. Birthplace SCOTKAND

MOTHER
14. Maiden name MARTIN, ELIZABETH
15. Birthplace SCOTLAND

16. Informant MEMORIAL HOSPITAL
Address CUMBERLAND

17. Burial (Burial, cremation, or removal. Which?) Date thereof Jan 26 1945 (month) (day) (year)
Cemetery or crematory Hillcrest Cemetery
Location Cumberland, Md
18. Funeral director John I. Hafer
Address Cumberland, Md.

19. Jan. 25, 1945 (Date rec'd by registrar) Winter R. Frantz, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH JAN. 23, 1945 19 ..... at ..... M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from November 1 19 44, to January 23 1945 and that I last saw him alive on January 22 1945

Immediate cause of death	DURATION
Carcinoma of Larynx	1 yr.
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations Carcinoma of Larynx
Date of op. Oct. 1944
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide ..... Date of .....
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE L. K. Meyers M.D. (M. D. or other)
Address Cumberland, Md. Date signed 1/24/45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

Dr. Meyers

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (15)

00084

CERTIFICATE OF DEATH

Reg. Diat. No. 4

1. PLACE OF DEATH:

County ALLEGANY

City or town CUMBERLAND
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 2 DAYS

Hospital, institution, or street address where death occurred:
MEMORIAL HOSPITAL

How long in hospital or institution? 2 DAYS

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State WEST VIRGINIA County MINERAL

City or town KEYSER, W.VA
(If outside city or town limits, write RURAL and give nearest town)

Street No. 202 ARGYLE STREET
(If rural, give LOCATION)

2.(a) If veteran, name war ✓

3. (a) FULL NAME STICKLEY, BABY BOY

3. (b) Social Security Number None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
MALE	WHITE	Single

6.(b) Name of husband or wife

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) January 12, 1945

8. AGE: Years | Months | Days | If less than one day: hrs. ..... min.
& 2

9. Birthplace Cumberland, Allegany Co., Md.
(Town, county, and state)

10. Usual occupation None

11. Industry or business

FATHER
12. Name STICKLEY, WILLIAM
13. Birthplace WEST VIRGINIA

MOTHER
14. Maiden name STAFFORD, MARY EVELYN
15. Birthplace WEST VIRGINIA

16. Informant MEMORIAL HOSPITAL
Address CUMBERLAND, MD.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Jan. 15, 1945 (month) (day) (year)

Cemetery or crematory Melrick Cem.

Location Augusta, W. Va.

18. Funeral director W. L. Rogers

Address Keyser, W. Va.

19. Jan. 15, 1945 (Date rec'd by registrar) Winter R. Beanty, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan 14 1945, at 6 P M

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from Jan 12 1945 to Jan 12 1945
and that I last saw him alive on Jan 14 1945

Immediate cause of death	DURATION
Prematurity	
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Morgan Daywalt M.D.
M. D. or other

Address Cumberland, Md. Date signed Jan 15 1945

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

DR. ELIASON

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (BH)

CERTIFICATE OF DEATH

00085

Reg. Diat. No. 4

1. PLACE OF DEATH:
County: Allegany
City or town: Cumberland, Maryland
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, Institution, or street address where death occurred: Memorial Hospital
How long in hospital or institution? 9 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Allegany
City or town: Cumberland
(If ontside city or town limits, write RURAL and give nenrest town)
Street No. 186 Thomas Street
(If rural, give LOCATION)
2.(a) If veleran, name war

3.(a) FULL NAME: George U. Tederick

3.(b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: Ida Valentine Tederick
6.(c) If alive, give age 67 years

7. Birth date of deceased (mo., day, yr.): July 21, 1867

8. AGE: Years	Months	Days	If less than one day
77	5	29	....hrs. ....min.

9. Birthplace: West Virginia (Town, county, and state)
10. Usual occupation: Retired Conductor
11. Industry or business: B. & O. R.R. Co.

FATHER
12. Name: Michael Tederick
13. Birthplace: West Virginia

MOTHER
14. Maiden name: Anne Kerns
15. Birthplace: West Virginia

16. Informant: Memorial Hospital
Address: Cumberland, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof Jan. 23, 1945 (month) (day) (year)
Cemetery or crematory: Rose Hill Cemetery
Location: Cumberland, Md.
18. Funeral director: Charles L. George
Address: Cumberland, Md.

19. Jan. 23, 1945 (Date rec'd by registrar) Walter R. Bantz M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: January 20, 1945, at 9:55P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan - 11, 1945 to Jan. 20, 1945
and that I last saw h... alive on Jan 20, 1945

Immediate cause of death	DURATION
Chronic Myocarditis	1 Yr
Chronic Nephritis	1 Yr
Due to Uraemia	10 days
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ....Date of op. ....
Antopsy results:
PHYSICIAN: Please underlioe the canse to which death should he charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: H. U. Eliason M.D. M. D. or other
Address: 136 Howard Cumberland Date signed: 1-23-45

M

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (74-a)

00086

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH:

County: Allegany

City or town: Cumberland
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 5 days

Hospital, Institution, or street address where death occurred: Memorial Hospital

How long in hospital or institution? 5 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Allegany

City or town: Rural Rawlings
(If outside city or town limits, write RURAL and give nearest town)

Street No. 5 miles south of Rawlings
(If rural, give LOCATION)

2.(a) If veteran, name war:

3.(a) FULL NAME: George Washington Turner

3.(b) Social Security Number: 236-14-6694

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: Emma Hise Turner

6.(c) If alive, give age: 36 years

7. Birth date of deceased (mo., day, yr.): February 28, 1883

8. AGE:

Years	Months	Days	If less than one day
61	10	20	...hrs. ...min.

9. Birthplace: Keyser, Mineral County, W. Va.
(Town, county, and state)

10. Usual occupation: Timber worker

11. Industry or business: Woodsman

FATHER
12. Name: Fisher Turner
13. Birthplace: Not known

MOTHER
14. Maiden name: Unknown
15. Birthplace: "

16. Informant: Mrs. Geo. W. Turner

Address: Rt. #1, Box 170, Keyser, W. Va.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Jan. 13, 1945 (month) (day) (year)

Cemetery or crematory: Flanigan Cem

Location: Near Rawlings, Md.

18. Funeral director: Ellsworth L. Boal

Address: Westernport, Md.

19. Jan 12 1945 (Date rec'd by registrar) Winter R. Tranty, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Jan - 10 1945, at 330 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan 7 1945, to Jan 10 1945 and that I last saw h[illegible] alive on Jan 10 1945

Immediate cause of death	DURATION
Spleno-myelogenous, Leukemia -	
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: C. M. Meekins M.D. M. D. or other

Address: 49 Greene St Date signed: 1-12-45

M

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

00087

Reg. Dist. No. 4

1. PLACE OF DEATH:

County: Allegany

City or town: Cumberland

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 44 yrs

Hospital, institution, or street address where death occurred: Allegany Hospital

How long in hospital or institution? 5 weeks

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Md County: Allegany

City or town: Cumberland

(If outside city or town limits, write RURAL and give nearest town)

Street No. 13 Marion St

(If rural, give LOCATION)

2.(a) If veteran, name war:

3.(a) FULL NAME: Alondos Victor Twigg

3.(b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: Rachael Smith

6.(c) If alive, give age: 69 years

7. Birth date of deceased (mo., day, yr.): Feb 4, 1873

8. AGE:

Years	Months	Days	If less than one day
71	11	27	hrs. min.

9. Birthplace: Flintstone, Allegany Co, Md (town, county, and state)

10. Usual occupation: Retired

11. Industry or business: Railway Express Co.

FATHER — 12. Name: Francis A Twigg

FATHER — 13. Birthplace: Flintstone, Md.

MOTHER — 14. Maiden name: Alice Kifer

MOTHER — 15. Birthplace: Flintstone Md.

16. Informant: Mrs. A. V. Twigg

Address: 13 Marion St.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Feb 2, 1945 (month) (day) (year)

Cemetery or crematory: Greenmount Cemetary

Location: Cumberland Md

18. Funeral director: John J. Hafer

Address: Cumberland Md.

19. Feb 2 1945 (Date rec'd by registrar) Winter R. Fantz, M Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: January 30 1945 at 4:30 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from January 14 1944 to January 30 1945 and that I last saw him alive on January 29 1945

Immediate cause of death	DURATION
~~Chron~~ congestive heart failure	6 weeks
Due to: chronic myocarditis	one year
Due to: pulmonary emphysema	20 yrs.
Other conditions: bronchial asthma	20 yrs.

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: L. Bruce MD M. D. or other

Address: Cumberland Md Date signed: 2-1-45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (93-d)

00088

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH:
County: Allegany
City or town: Cumberland
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, Institution, or street address where death occurred: Memorial Hospital
How long in hospital or institution? 4 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Pennsylvania County: Bedford
City or town: Hyndman
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war: V

3.(a) FULL NAME Hiram N. Van Voorhis

3.(b) Social Security Number None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: Gyneth Shull Van Voorhis
6.(c) If alive, give age: 52 years

7. Birth date of deceased (mo., day, yr.): August 16, 1882

8. AGE:

Years	Months	Days	If less than one day
62	4	13	hrs. min.

9. Birthplace: Portage Co. Ohio
(Town, county, and state)
10. Usual occupation: Minister
11. Industry or business

FATHER
12. Name: David Van Voorhis
13. Birthplace: Ohio

MOTHER
14. Maiden name: Emma Beard
15. Birthplace: Ohio

16. Informant: Mrs. Gyneth Van Voorhis
Address: Hyndman, Pa.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Jan. 5 1945 (month) (day) (year)
Cemetery or crematory: Bowling Green Cemetery
Location: Bowling Green Ohio

18. Funeral director: Harvey H. Zeigler
Address: Hyndman Pa.

19. Jan 3 1945 Winter R. Bantz M.D.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Jan 1 1945, at 10 30 M

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from Dec 27 1944, to Jan 1 1945
and that I last saw h... alive on Jan 1 1945

Immediate cause of death: Chronic Myocardosis — DURATION: 4 yrs
Due to:
Due to:
Other conditions:
(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: John A Topper MD
M. D. or other
Address: Hyndman Pa. Date signed: 1-2-45

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (17-2)

CERTIFICATE OF DEATH

00089

Reg. Dist. No. 4

1. PLACE OF DEATH:

County: Allegany

City or town: Cumberland Md

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred: Allegany Hospital Cumberland, Md.

How long in hospital or institution? 29 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Allegany

City or town: Cumberland Md

(If outside city or town limits, write RURAL and give nearest town)

Street No. 514 N. Mechanic St.

(If rural, give LOCATION)

2.(a) If veteran, name war: World War I

3. (a) FULL NAME: Saul Baingold

3. (b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: Alice Knight

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): Feb. 15, 1899

8. AGE: Years	Months	Days	If less than one day
45	10	17	..... hrs. ..... min.

9. Birthplace: Poland

(Town, county, and state)

10. Usual occupation: Auto Dealer

11. Industry or business: Automobile business

FATHER 12. Name: Nathan Baingold

13. Birthplace: Poland

MOTHER 14. Maiden name: Rachel

15. Birthplace: Poland

16. Informant: Mrs. Saul Baingold

Address: Cumberland Md.

17. Burial. (Burial, cremation, or removal. Which?) Date thereof 1/3/45 (month) (day) (year)

Cemetery or crematory: East End Cem.

Location: Cumberland, Md.

18. Funeral director: Louis Steinberg

Address: Cumberland Md.

19. Jan. 3 1945 (Date rec'd by registrar) Walter R. Stanton M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Jan. 2nd 1945, at 9:17 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 12/4/44 19.. to 1/2/45 19..

and that I last saw h.. alive on 1/2/45 19..

Immediate cause of death: Gastric ulcers - Gastric Hemorrhage

DURATION

Due to: .....

Due to: .....

Other conditions: .....

(Include pregnancy within 3 months of death)

Major findings of operations: .....

Date of op. .....

Autopsy results: .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

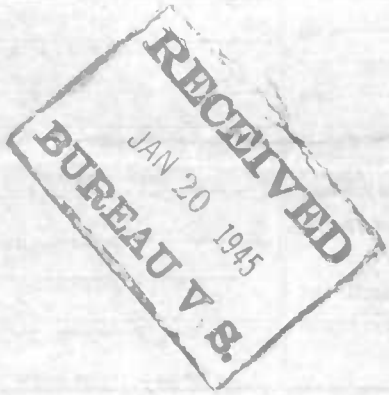
23. SIGNATURE: John K. Rozum M.D. M. D. or other

Address: Cumberland Md. Date signed 1/3/45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15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MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 186a

00690

CERTIFICATE OF DEATH

Reg. Diat. No. 4

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County ALLEGANY

City or town CUMBERLAND MD
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 40 yrs.

Hospital, institution, or street address where death occurred:
MEMORIAL HOSPITAL

How long in hospital or institution? 1 DAY

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State MARYLAND County ALLEGANY

City or town CUMBERLAND
(If outside city or town limits, write RURAL and give nearest town)

Street No. 216 PARK STREET
(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME
MRS. ELLA G. WILSON

3.(b) Social Security Number
None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
FEMALE	WHITE	MARRIED

6.(b) Name of husband or wife OWEN WILSON

6.(c) If alive, give age 80 years

7. Birth date of deceased (mo., day, yr.) SEPT 16 1868

8. AGE: Years	Months	Days	If less than one day
76	4	12	...hrs. ...min.

9. Birthplace MD.
(Town, county, and state)

10. Usual occupation HWIFE

11. Industry or business

FATHER
12. Name HENRY NORTH ~~DECEASED~~
13. Birthplace MD

MOTHER
14. Maiden name ELIZ. ATHEY ~~DECEASED~~
15. Birthplace MD

16. Informant MEMORIAL HOSPITAL
Address CUMBERLAND, MD.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Jan 30 1945 (month) (day) (year)

Cemetery or crematory Rose Hill Cem.

Location Cumberland, Md.

18. Funeral director Louis Stein, Inc.

Address Cumberland, Md

19. Jan. 30 19 45 (Date rec'd by registrar) Winter R. Frantz, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH JANUARY 28 19 45 at 11:15 A. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 1-27- 19 45 to 1-28- 19 45 and that I last saw h... alive on 1-27- 19 45

Immediate cause of death	DURATION
Cerebral Thrombosis	
Due to	
Due to	
Other conditions Fracture Rt. Clavicle & Rt. Femur (Include pregnancy within 3 months of death) 1-27-45	

Major findings of operation None

Date of op. None

Autopsy results None

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE W. F. Williams M. D. or other

Address Cumberland Date signed 1-28-45

DR. WILLIAMS

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

00091

CERTIFICATE OF DEATH

Reg. Dist. No. 9

1. PLACE OF DEATH:

County: Allegany

City or town: Frostburg
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 35 years

Hospital, institution, or street address where death occurred:
Miners Hospital

How long in hospital or institution? 2 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Allegany

City or town: Frostburg
(If outside city or town limits, write RURAL and give nearest town)

Street No. 121 Armand Street
(If rural, give LOCATION)

2.(a) If veteran, name war:

3.(a) FULL NAME: John Andrew Wilson

3.(b) Social Security Number: 217-096-357

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: Katie V. Wilson

6.(c) If alive, give age: 58 years

7. Birth date of deceased (mo., day, yr.): October 16, 1887

8. AGE: Years	Months	Days	If less than one day
57	3	10	...hrs. ...min.

8. Birthplace: Midlothian Allegany Co., Md.
(Town, county, and state)

10. Usual occupation: Rubber Worker

11. Industry or business: Kelly-Springfield Tire Co.

FATHER
12. Name: Theodore Wilson
13. Birthplace: Midlothian Md.

MOTHER
14. Maiden name: Rebecca Schell
15. Birthplace: Virginia

16. Informant: Mary Katherine Wilson
Address: 121 Armand St. Frostburg, Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Jan. 29 1945 (month) (day) (year)

Cemetery or crematory: St. Michaels Cemetery

Location: Frostburg Md.

18. Funeral director: Jacob Hafer

Address: Frostburg Md.

19. 1-27 1945 Mrs. Nancy H. Rose
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Jan 26 1945, at 2:15 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan 24 1945 to Jan 26 1945 and that I last saw him alive on Jan 25 1945

Immediate cause of death	DURATION
Coronary Thrombosis	2 Days
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ...Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: W O McClane Jr M.D.
M. D. or other

Address: Frostburg Md. Date signed: 1-27-45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correctness is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15